

VENTURA COUNTY SELPA
EARLY START PROGRAM

www.venturacountyselpa.com

OPERATIONS MANUAL FOR

**School District
Early Childhood
Special Educators (ECSE)**

Serving Infants/ Toddlers 0 – 36 months



“Baby Bootee Camp”

Guide

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INTRODUCTION

Welcome to Ventura County SELPA Early Start Program. Adopted in 1991 in the state of California, Early Start is an innovative, visionary program that provides family-focused services to infants and toddlers with disabilities. The goal of the program is to provide early intervention to assist children in developing their fullest potential.

Early Start is a program unlike any other public school special education program. It requires ongoing collaboration with the Regional Center for intake, assessment, service delivery and transition. It utilizes a planning process (Individualized Family Service Plan - IFSP) and service delivery model components (home-based services, nutrition and respite services) that are unique.

In addition, every local education agency in California has developed their own working system with their local regional center. Therefore, what we do in Ventura County SELPA is different than other places in the state.

All IFSP forms and most other documents to be used with families are also available in Spanish. See the SELPA website for all IFSP forms at www.venturacountyselpa.com/ “Early Childhood”/ “Infant/ Toddler.”

This manual was designed to assist you as you enter our program. Welcome to “Baby Bootee Camp”.

Thanks to the following staff for the 2010 revisions:

Keisha Carroll and Rama Dasu, Simi Valley USD, Early Childhood Special Educator

Raelynne Lorenz, Conejo Valley USD, Early Childhood Special Educator


Karly Stern, Ventura USD, Early Childhood Special Educator

Gina Villavicencio, VC SELPA, Secretary



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**ROLES AND
RESPONSIBILITIES
of School District
ECSE**



ROLES AND RESPONSIBILITIES OF SCHOOL DISTRICT EARLY CHILDHOOD SPECIAL EDUCATOR (ECSE)

Roles and responsibilities include the following but are not limited to:

SERVICE COORDINATOR:

- Develop IFSP
- Initiate referrals for other specialized assessments
- Coordinate services listed on IFSP
- Referral to community resources
- Adhere to State and Federal laws including timelines

* Service Coordinators within the schools may also serve as Service Providers.

SERVICE PROVIDER:

- Complete developmental assessment
- Attend IFSP
- Assist in developing appropriate measurable outcomes with the family
- Provide special instruction, family training, counseling, and home visits
- Develop reports of progress

The Early Start Program in the public schools provides services to children **200 days per year**. In addition, the school district ECSE must be available to receive and act upon referrals of Solely Low Incidence children **12 months per year, each business day**.

Each Early Start program will serve eligible Infants/ Toddlers according to the “minimum” number on the attached chart, as per December 1 pupil count.



VC SELPA
Early Start Program
Caseloads

	Units	(Optimal) Units x 14	(Minimum) Units x 12	%
Simi Valley	2.61	37	32	32
Ventura	2.48	35	30	31
Oxnard	1.42	20	18	18
Conejo Valley	1.53	22	19	19
SELPA TOTAL:	8.04 units			



REFERRAL

REFERRAL

Infants and toddlers can be referred to the Early Start program by any interested individual. This is typically done by a parent or guardian, doctor or other medical personnel, therapist, day care provider or education staff.

In Ventura County, the Early Start Program has a “*single point of entry*,” which is Tri-Counties Regional Center (TCRC, phone (800) 664-3177). Children from Los Angeles County, residing in Ventura County SELPA school districts are referred to North LA County Regional Center (NLARC, phone (818) 778-1900).

TCRC staff will complete an Early Start Inquiry page (attachment), acquiring important information about the child and the concerns. The referral date is the date on which the Inquiry Sheet was completed. TCRC will assign an Interim Service Coordinator for the child.

TCRC will forward the Early Start Inquiry page to the appropriate school district program immediately. The school district ECSE is responsible for children within the catchment of the school districts they serve. (See attached Interdistrict Program Chart)

The process for intake is known as Dual Agency Review Team (DART). During the DART process, infants will be considered for one of the following service coordination options:

➤ **Solely Low Incidence (SLI)**

The school district ECSE is responsible to serve all infants/ toddlers with solely a vision impairment, hearing impairment, or orthopedic impairment, or any combination of those disabilities. These infants/ toddlers are not served by TCRC, and will receive services from the school district even if their caseload is full. The school district ECSE is the Service Coordinator.

➤ **Regional Center Services only**

TCRC is responsible for all eligible infants/ toddlers who will not be served by the school district ECSE at all.

➤ **Dually Served**

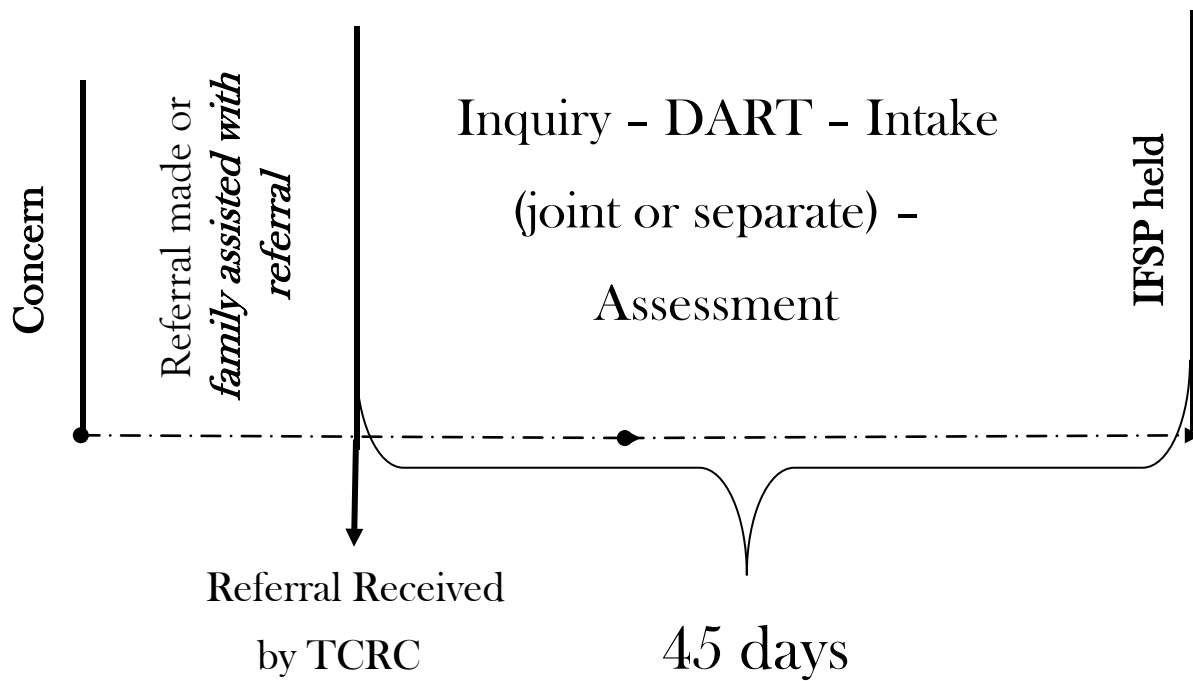
If the school district ECSE has openings in their caseload, they can provide special education services to the child, with TCRC retaining service coordination responsibilities. According to the 2010 Memorandum of Understanding (MOU) between TCRC and Ventura County SELPA, the following infants/ toddlers are priorities for dual service delivery:

- * Children who would benefit from vision or hearing services; or
- * Children with California Children Services (CCS)- Medical Therapy Program (MTP) eligible diagnoses; or
- * Children who exhibit multiple handicaps, especially those with cognitive impairments and other disabilities.

It is important to note that a child's initial service coordination status (SLI, RC services only or, dually served) may change when the intake team meets the child and completes the assessment process. In that case, the child is referred back to the DART team to reconsider agency services.

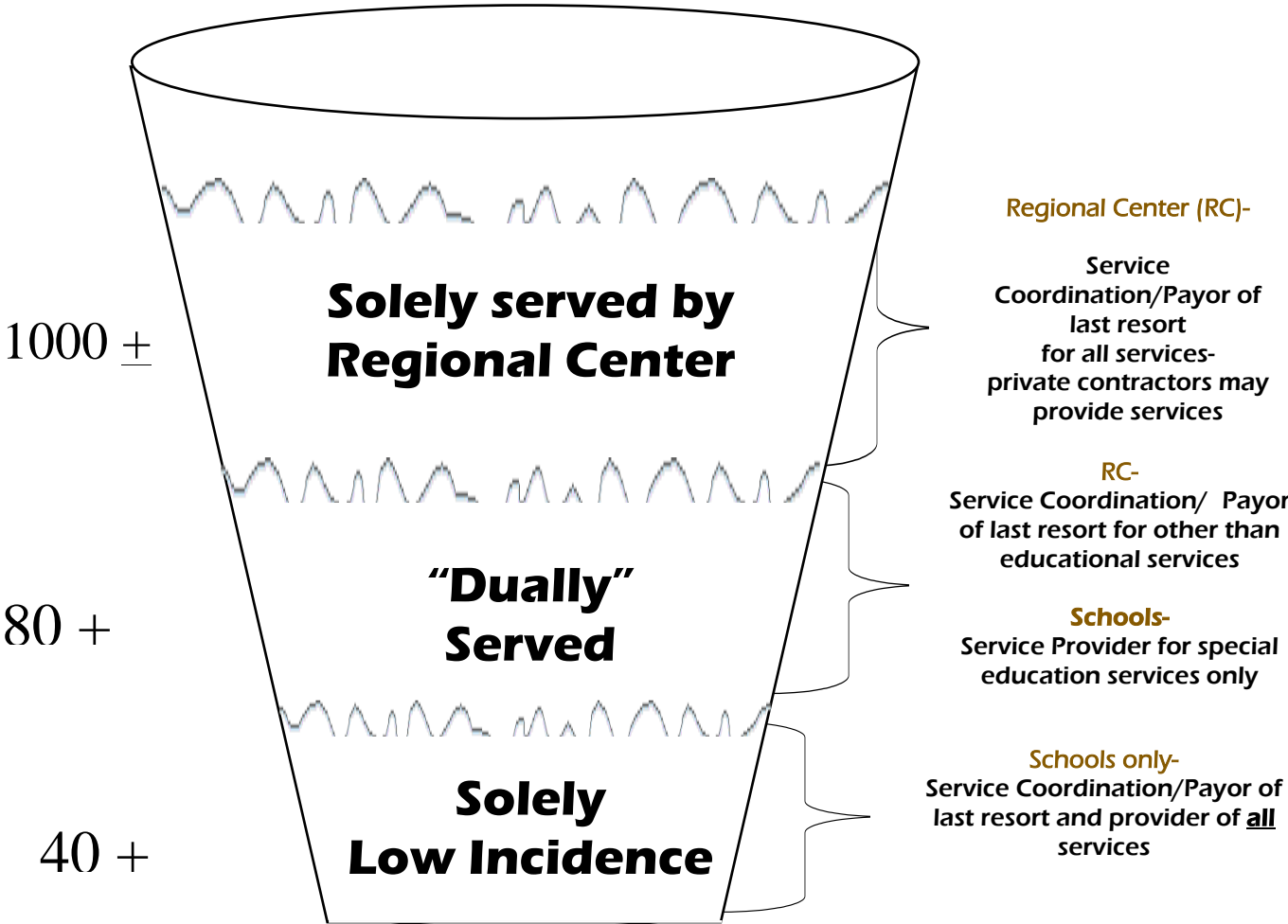


The school district ECSE will respond to DART within 48 hours via phone, email, or fax. Once a referral is received by TCRC, the 45 day timeline begins. During the 45 day time line the following must occur: intake interview, assessment and Initial IFSP.





The following graphic demonstrates proportional numbers of children served by the various service delivery options.





The SELPA Early Start Secretary will forward to each infant/ toddler program a list of all Inquiries (See sample attached) completed by TCRC each week.

The SELPA Early Start Secretary will forward to each school district in the SELPA a list of Early Start Intakes received for children residing in the district, on a quarterly basis.

Ventura County Early Start Program EARLY START INQUIRY

Initial Intake Date: _____	IFSP Due Date: _____	SSN# _____	UCI# _____
Child's name: _____ Date of Birth: _____ Age: _____ Gender: _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Last First MI </div>			
Mother/Guardian: _____ Maiden Name: _____ Father: _____			
Parent Consent to Referral: <input type="checkbox"/> Yes <input type="checkbox"/> No Do Parents live together? _____ Primary Language: _____ Interpreter? _____			
Mailing/Home Address: _____			
Phone: _____ Message Phone: _____ School District of Residence: _____			

Is child in Foster Care? Yes No (If yes, see over)

Inquirer's Name: _____ Relationship to the Family: _____ Contact Phone _____

Has applicant ever applied for services from any regional center? Yes No Where? _____

Primary physician: _____ Telephone: _____

Other agencies involved: _____ Medical Info Attached: _____

Parent was informed that Early Start is a partnership between DDS and Dept of ED and information will be shared between TCRC and the LEA, and parents agreed to proceed. Yes No

HISTORY AND CONCERNS:

Birthplace: _____ Hospital: _____ Gestational Age: _____ Birth weight: _____

Present weight: _____ Medications and Equipment: _____

Medical Confirmation/Diagnosis: _____ Specialist(s) Involved: _____

Developmental Concerns:

For details: (See over)

Inquiry taken by: _____ Phone #: _____ Ext: _____

Regional Center Service Coordinator assigned _____ Phone #: _____ Ext: _____

Date of follow up – phone call to family (if appropriate): _____ How did you hear about Early Start: _____

Actions taken: Appears SLI-sent to LEA Faxed to LEA for consideration for dual Date _____

School District Response: _____ Possible Dates for Joint Intake: _____

LEA Early Start Coordinator:	LEA Response Date:
<input type="checkbox"/> Yes- agree to serve as SLI (Pending evaluation results)	<input type="checkbox"/> No- does not appear appropriate for dual/no available openings at this time
<input type="checkbox"/> Yes- agree to dual intake	<input type="checkbox"/> No- reconsider at later date when more information is available
Concerns/ Need More Info:	

**Ventura County Early Start Program
EARLY START INQUIRY (continued)**

ADDITIONAL DETAILS FOR CHILDREN IN FOSTER CARE

Does Biological Parent Retain Education rights? Yes No (if no) explain: _____

Is Biological parent living in the area? Yes No (if no) explain: _____

Biological Parent's Name(s): _____ Tel #: _____

Address: _____

Is Biological parent available to sign consent to evaluate? Yes No (if no) explain: _____

Is visitation supervised? Yes No (if no) explain: _____

Visitation Schedule: Day(s) _____ Time _____ Location: _____

Copy of court order requested? Yes No Explain: _____

Name of CFS caseworker: _____

Phone number: _____

Details: _____

DEVELOPMENTAL CONCERNS / OPTIONAL

Developmental Concerns	Description of concerns
<input type="checkbox"/> Vision	
<input type="checkbox"/> Hearing *see checklist	
<input type="checkbox"/> Physical *see checklist	
<input type="checkbox"/> Self-help *see checklist	
<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Social	
<input type="checkbox"/> Communication	
<input type="checkbox"/> Cognitive	

*Physical Checklist: (Circle all that apply): rolls tummy to back, sits unsupported, belly crawls, crawls, pulls to stand, cruises furniture, walk, grasps toy, releases toy.

*Self Help Checklist: (Circle all that apply): Holds a bottle with both hands, finger feeds, drinks from open cup, uses a spoon to feed

*Newborn Hearing Screening Passed: Yes No

Interdistrict Program Chart Early Intervention Services (0-2 year olds)

SERVICE COORDINATION REGION	Speech/Language	Assistive Technology Assessment	Audiological Services	Orientation & Mobility	Nutrition*	Respite*	Transportation to educational services	Physical Therapy*	Occupational* Therapy	Vision Services	Vision Therapy	Counseling and Guidance Services	Psychological Services (Non Assessment)	Parent training	Health and Nursing	Social Work Services	Recreation Services	Deaf	Hard of Hearing Services	Parent Counseling
Conejo Valley USD (C)	C	SELPA	VC	C	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	C	C	C/BH	C/BH	SELPA/ FRC	C	C/BH/RC/ SELPA	RD	SV/SELPA	C/SELPA ; Consult- SV	C/RC/B H/ SELPA
Oxnard Elementary SD (OE)	OE	SELPA	VC	H	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	OE	OE	OE/BH	OE/BH	SELPA/ FRC	OE	OE/BH/RC/ SELPA	RD	¹ V/SELPA	O/SELPA; Consult-V	OE/RC/ BH/ SELPA
Ventura Unified SD (V)	V	SELPA	VC	H	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	V	V	V/BH	V/BH	SELPA/ FRC	V	V/BH/RC/ SELPA	RD	V/SELPA	V/SELPA	V/RC/B H/ SELPA
Simi Valley Unified SD (SV)	SV	SELPA	VC	C	SELPA	SELPA	SELPA	CCS/ SELPA	CCS/ SELPA	SV	SV	SV/BH	SV/BH	SELPA/ FRC	SV	SV/BH/RC /SELPA	RD	SV/SELPA	SV/SELP A	SV/RC/ BH/ SELPA

Hueneme (H)

California Children Services (CCS)
City Recreation Department (RD)
Family Resource Center (FRC)

Regional Center (RC)

Ventura County Behavioral Health (BH)

Ventura County Special Education Local Plan Area (SELPA)

Ventura County Office of Education (VC)

- Services provided to Solely Low Incidence only

¹ Except Somis & Pleasant Valley - served by Simi

DISTRICTS EACH REGION SERVES:

Conejo

Conejo Valley Unified School District
Las Virgenes Unified School District
Oak Park Unified School District

Oxnard Elementary

Hueneme School District
Mesa Union School District
Pleasant Valley School District
Rio School District
Ocean View School District
Oxnard School District
Somis Union School District

Simi Valley

Moorpark Unified School District
Simi Valley Unified School District
Somis & Pleasant Valley (Deaf only)

Ventura Unified

Briggs School District
Fillmore Unified School District
Mupu School District
Ojai Unified School District
Santa Paula Elementary School District
Ventura Unified School District

INTAKE INTERVIEW

INTAKE INTERVIEW

After an infant is referred to the Early Start program and has gone through the DART process, the Service Coordinator contacts the family to arrange an intake interview. (See attached Intake Interview worksheet.) If the child may be dually served, the intake interview with the family will include a representative from TCRC and the school district. The representative from TCRC and the school district will make every effort to go out together to complete the intake interview.

Parent Consent will be obtained to gather information from medical practitioners or other providers. (See attached form.)

If the child needs a hearing assessment, the family will be referred to Hearing Conservation. (See attached form.)

All families will be given a referral to the Rainbow Connection Family Resource Center upon intake. (See attached form.)

Ventura County Early Start Program
EARLY START INTAKE INTERVIEW WORKSHEET

Date of Report: _____	Dual case: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name: _____	UCI: _____	DOB: _____

IDENTIFYING INFORMATION:

Age: _____ Sex: M F Ethnicity: _____

Address: _____

Phone Number: _____ Legal Status: _____

Who does the child reside with? _____ Natural Parents: Yes No _____

Foster Parents: Yes No _____ CPS Worker: Yes No _____

By whom referred: _____

Risk Factors: _____

Reason for concern (*congenital anomalies, prematurity, diagnosis, etc.*): _____

Location of interview: _____

Persons attending intake: _____

Health Insurance: _____

FAMILY SITUATION:

Mother: _____ Maiden Name: _____ DOB: _____

Age: _____ Educational Background _____ Degree: _____

Vocation: _____

History of disabilities (*i.e. learning, special needs, CP, autism, etc.*): _____

Father: _____ DOB: _____ Age: _____

Educational Background _____ Degree: _____

Vocation: _____

History of disabilities (*i.e. learning, special needs, CP, autism, etc.*): _____

Sibling's Name: _____ DOB: _____ Age: _____

Education: _____ Where does sibling reside? _____

Sibling's Name: _____ DOB: _____ Age: _____

Education: _____ Where does sibling reside? _____

Sibling's Name: _____ DOB: _____ Age: _____

Education: _____ Where does sibling reside? _____

MOTHER'S PRENATAL HISTORY:

Mother's medical history

Mom's health during pregnancy: _____

Due Date: _____ Maternal age at time of birth: _____ Prenatal Care: Yes No

At what month received: _____ Who provided care: _____

Problems during pregnancy

- | | | | |
|--|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chronic Disease | <input type="checkbox"/> Rh Incompatibility | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Viral Infection | <input type="checkbox"/> Vaginal Bleeding | <input type="checkbox"/> Toxemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> UTI | <input type="checkbox"/> Miscarriages | <input type="checkbox"/> Other | |

Comments: _____

Substance exposure

One month prior- What was your use of alcohol? _____

What was your use of tobacco? _____

What was your use of recreational drugs? _____

What was your use of prescriptions? _____

During pregnancy- What was your use of alcohol? _____

What was your use of tobacco? _____

What was your use of recreational drugs? _____

What was your use of prescriptions? _____

What was your use of prenatals/folic acid/iron? _____

BIRTH HISTORY:

Fetal Movement: _____ At what month: _____

Hospital of birth: _____ Length of labor: _____

Gestational Age (<32 weeks): _____

Apgars (5 minutes between 0-5): _____ 1 minute _____ 5 minutes _____ 10 minutes

Birth Weight (1500 grms/3 lbs 5 oz): _____ Length: _____

Delivery

- Normal C-Section Induced Labor Premature (____ weeks)
- Breech Jaundiced Cord Around Neck Transfused
- Fever Twin (1st or 2nd) Rh-incompatible Baby Rotated
- Transverse Abrupton Placenta Previa Meconium Aspiration/Stained
- Other Comments: _____

Regular nursery course: _____ NICU: _____

Transport to other hospital: Yes No Name: _____

Reason: _____

- Oxygen/Ventilator Respiratory Distress Syndrome Bronchio-Pulmonary Disease Apnea and Bradycardia
- Intracranial Hemorrhage (grade): _____ Other: _____

Surgeries: Yes No Seizures: Yes No Congenital Anomalies: Yes No

Patent Ductus Arteriosus: Yes No Retinopathy of Prematurity: Yes No Genetic Syndrome: Yes No

Comments: _____

HOSPITAL STAY:

Length of stay- Mom: _____ Baby: _____

Equipment Needed: _____ Tube/Gavage Feedings: _____

Test/Evaluation: _____

Discharge instructions (equipment, medication, etc.):

Comments: _____

BABY/CHILD CURRENT STATUS:

Current Health: _____ Current Weight: _____ Height: _____

Vitamins: Yes No Medications: Yes No Type: _____ Dosage/Frequency: _____

Reason: _____ Dr. who prescribed medications: _____

MEDICAL FOLLOW UP:

Pediatrician: _____ Last Visit: _____ Next: _____

Specialist: _____ Appointment: _____
Specialist: _____ Appointment: _____
Follow-up Clinic: _____
Immunizations Up-to-Date: Yes No Explain: _____

Medical problems

Tone Issues: Hypo? Hyper? Upper Extremities Lower Extremities
Re-hospitalizations: Yes No What Hospital: _____
Length of each: _____
Illness: _____ Surgeries: _____ Seizures: _____ Allergies: _____

Nutrition

Breast Feeding: Yes No How Much: _____ How Often: _____
Formula: Yes No Which: _____ How Much: _____ How Often: _____
Other Foods/Supplements (*types, amount, frequency*): _____
How Often: _____

Hearing

Formal hearing evaluation: Yes No When: _____ Where: _____
Results: _____
 Referred to Hearing Conservation: (805) 388-4438 on _____

Vision

Formal vision evaluation: Yes No When: _____ Where: _____
Results: _____
 Referred to: _____

Adaptive equipment

Yes No Reason: _____ Type: _____
Comments: _____

OTHER AGENCIES INVOLVED:

WIC: Yes No Medi-cal: Yes No CPS: Yes No SSI: Yes No CCS: Yes No
Other: _____

ADVANCED SCREENING:

Sensory issues

Is s/he sensitive to: Sounds: Yes No Touch: Yes No Brightness: Yes No

Other: _____

Regulation issues

Daily Schedule: Sleeping (*including naps*) _____

Eating: Picky Eater Yes No How Often: _____ Size of Serving: _____

Transition issues

Does s/he have difficulty with changes?: People: Yes No Places: Yes No

Daily Schedule: Yes No Going from one activity to the next: Yes No

Attention

Is s/he: Over focused on one thing at a time: Yes No Not able to focus: Yes No

Other: _____

Behavior issues (*consider age appropriateness and extent and frequency of behavior*)

Is s/he: Too Passive: Yes No Overwhelmed: Yes No Easily Upset: Yes No

Angers Quickly: Yes No Bites, Pinches others: Yes No Screams: Yes No

Throws Things: Yes No Excessive Irritability: Yes No

Ventura County Early Start Program

PARENT CONSENT

For Assessment/Evaluation, Release/Exchange of Information, Request for Service

Child's Name: _____	DOB: _____
---------------------	------------

With your written consent, community agencies and the persons who represent them may share information with one another. Evaluation for the Early Start Program includes: finding out if your child is eligible for services, talking about what services are available, matching services to your child and family needs.

You need to know that:

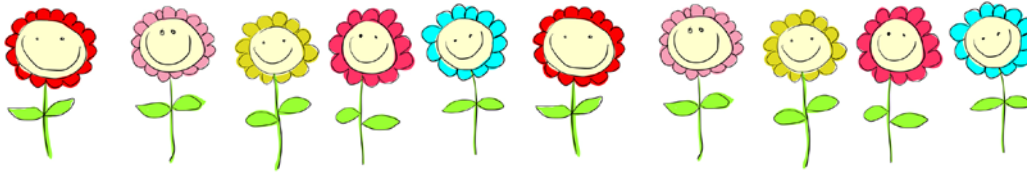
- Your child may receive a developmental assessment.
- The information obtained is voluntary and will only be used to evaluate your child to determine his/her eligibility and need for services and provision of an Individual Family Service Plan.
- You may request copies of all records pertaining to your child.
- This consent for exchange is good for one year; you may withdraw your permission at any time by writing a note to your primary service coordinator. However, revocation of your permission will not apply to records already released.
- A photocopy of this document is as valid as the original.
- Sharing information helps agencies coordinate services for your child. You may choose which agencies shall exchange information.
- Information about your child and family is strictly confidential and will only be released to agencies and/or persons whom you choose in writing.
- You may refuse to sign this exchange form.
- You must be informed of the contents of this document in language you clearly understand.
- Information to be exchanged includes medical and health, developmental, speech and language, educational, hearing/vision and/or psychological.
- A copy of your parental rights which includes information regarding services which may be offered to the child and/or the family as part of the Early Start services, is attached.

I request coordination of Early Start services and agree to the exchange of information among the agencies checked below and the persons who represent them.

- | | |
|--|--|
| <input type="checkbox"/> Tri-Counties Regional Center (TCRC) | <input type="checkbox"/> Family Resource Center |
| <input type="checkbox"/> Local Education Agency/Vendor | <input type="checkbox"/> Primary Care Physician, Clinic please specify |
| _____ | _____ |
| _____ | _____ |
| <input type="checkbox"/> County Health Department including Public Health Nursing and California Children's Services (CCS) | <input type="checkbox"/> Hospital _____ |
| | <input type="checkbox"/> Other _____ |

I understand that I may limit what information is exchanged. List any limitations: _____

I acknowledge that I have received a copy of the Parents' Rights & Responsibilities Regarding Evaluation and Assessment in the Early Start Program under IDEA.	
_____	_____
<i>Parent/Guardian</i>	<i>Date</i>
_____	_____
<i>Parent/Guardian</i>	<i>Date</i>



Ventura County Office of Education
Hearing Conservation
5100 Adolfo Rd.
Camarillo, CA 93012
(805) 437-1380 FAX: (805) 389-4297

Audiological Referral

Date: _____

An audiological evaluation is recommended. This can be arranged as a service of the Ventura County Office of Education. Appointments are scheduled by calling the Hearing Conservation Office at (805) 437-1380. Please plan on scheduling 6 - 8 weeks in advance. Testing may take from 30 minutes to 1 hour.

Student's Name: _____ Birth Date: _____

Address: _____

School: _____ District: _____

Referred By: _____ Title: _____

Address: _____

Telephone: _____

Reason for Referral: _____

Please bring this form with you to the appointment.

Location: Ventura County Office of Education
Conference and Educational Services Center
Hearing Conservation: Audiology Services
5100 Adolfo Road
Camarillo, CA 93012

Ventura County Early Start Program
Referral process for children with hearing impairments, 0-36 months

1. Results of Newborn Hearing Screening evaluations in Ventura County are forwarded by various medical facilities to the Southern California Hearing Coordination Center, then to the CA Department of Education, Deaf/Hard of Hearing department. In turn, CDE contacts Ventura County Office of Education Hearing Conservation (HC) (Kathy Huff, Coordinator). HC then continues the referral process to the VC Early Start Program.

In addition, infants who are suspected of having a hearing loss may be referred to the VC Early Start program by medical offices, family members, or other interested parties.

2. In the VC Early Start Program, Regional Centers are the 'single point of entry' for all infant referrals, 0-36 months. Infants who have, or are suspected of having, a hearing impairment should be referred to the appropriate Regional Center office (see appendix I for guidelines):

North Los Angeles County Regional Center	(818) 778-1900
Tri-Counties Regional Center East Office	(805) 522-8030
Tri-Counties Regional Center West Office	(805) 485-3177

3. The Regional Center office will complete an Early Start Inquiry Form, and send it by email or fax to the Early Start Service Area Program which serves the infant's home school district (see appendix II for guidelines):

Conejo Valley USD Service Area	Fax NA	email: lorenc@conejo.k12.ca.us
Oxnard Elem SD Service Area	Fax (805)	email: emcclelland@oxnardsd.org
Simi Valley USD Service Area	Fax (805) 520-6105	email: kcarroll@simi.k12.ca.us rdasu@simi.k12.ca.us
Ventura USD Service Area	Fax (805) 672-0427	email: launice.walker@venturausd.org karly.stern@venturausd.org

4. Before responding to the RC inquiry, the home Service Area Early Childhood Special Educator (ECSE) will review the inquiry to determine the extent of the infant's hearing impairment. If there is a bilateral moderate-severe-profound hearing loss (Deaf infant), the home Service Area ECSE will refer the infant to the appropriate Deaf/Hard of Hearing Service Area ECSE (see appendix III for guidelines), who becomes the designated school district of service to respond to the inquiry, and follow up with the referral.

If there is a unilateral hearing loss, a bilateral mild hearing loss, or a conductive hearing loss (Hard of Hearing infant), the home Service Area ECSE will respond to the inquiry and follow the referral. The D/HH Service Area ECSE will provide consultation services to the home Service Area ECSE.

5. The designated school district Early Start ECSE will respond to the Regional Center by email or fax within 48 hours. One of the following responses will be indicated:

- Agrees to dual intake
- Agrees to serve as solely low incidence
- Declines to serve (not SLI, and no opening or not a priority for dual)
- Agrees to reconsider at a later date when assessment report is available

Dual Intake: Infants who present with multiple concerns may be considered for 'dual' status, if the designated school district Early Start Program has openings. In dual status, the RC is the family's Service Coordinator, and provides most Early Start services. The SD provides special education and related services (see MOU, Appendix B). If the SD has no openings, dual referrals may be declined and RC remains the interim Service Coordination agency.

Solely Low Incidence Intake: Infants whose only presenting concern is hearing loss and who qualify for the ES program will be accepted by the designated SD as 'solely low incidence', regardless of whether the SD ES program has openings or is full. In SLI status, the SD Early Childhood Special Educator is the family's Service Coordinator, and SD/SELPA will be responsible for all Early Start educational services. Additional ES agencies may participate, such as CCS.

Note: Infants with hearing impairment sometimes appear to have multiple concerns (delays in communication, social, or other skills). If developmental delays are a direct result of the hearing impairment, infants should be considered for 'solely low incidence' status. If the delays are the result of a concomitant condition (prematurity, syndrome, illness), the infant should be considered for 'dual' status.

6. Following the designated SD's response to the ES inquiry, the designated ECSE will continue with MOU policies for SLI or dual intakes (see MOU, section V-C).

Appendix I. The following Regional Center offices are considered the ‘single point of entry’ for all initial infant referrals, including Deaf/Hard of Hearing infants, who reside in these areas:

North Los Angeles County Regional Center: Las Virgenes USD, (resident of LA County)

Tri-Counties Regional Center East Office: Conejo Valley USD, Moorpark USD, Oak Park USD, Simi Valley USD, Las Virgenes USD (resident of Ventura County)

Tri-Counties Regional Center West Office: Briggs ESD, Fillmore USD, Hueneme ESD, Mesa Union SD, Mupu ESD, Ocean View SD, Ojai USD, Oxnard ESD, Pleasant Valley ESD, Rio SD, Somis Union SD, Santa Clara ESD, Santa Paula ESD, Ventura USD

Appendix II. Regional Center will use the following list of school district Early Start Programs for all initial infant referrals, including Deaf/Hard of Hearing infants, who reside in these areas:

Conejo Valley USD Early Start Program: Conejo Valley USD, Las Virgenes USD, Oak Park USD. Contact person: Raelynn Lorenz, ECSE, (805) 492-4051 x220

Simi Valley USD Early Start Program: Moorpark USD, Simi Valley USD.
Contact persons: Keisha Carroll, ECSE. (805) 520-6700 x2658.
Rama Dasu, ECSE, (805) 520-6700 x2658.

Oxnard Elementary SD Early Start Program: Hueneme ESD, Mesa Union SD, Ocean View SD, Oxnard ESD, Pleasant Valley ESD, Rio SD, Somis Union SD.
Contact person: Elizabeth McClelland, ECSE, (805) 385-1518 x2149.

Ventura USD Early Start Program: Briggs ESD, Fillmore USD, Mupu ESD, Ojai USD, Santa Clara ESD, Santa Paula ESD, Ventura USD.
Contact persons: Karly Stern, ECSE, (805) 672-2705 x2219.
Launice Walker, ECSE, (805) 672-2705 x2213.

Appendix III. School districts will refer Deaf infants to the following school district Deaf/Hard of Hearing Early Start Programs (Hard of Hearing infants will be served by their home school district Early Start Program, with consultation provided by the following D/HH ES Programs):

Simi Valley USD Early Start D/HH services:
All districts within the Conejo Valley USD Early Start Program and the Simi Valley USD ES Program.
Contact person: Pat Schulz, VC SELPA, (818) 388-4581

Ventura USD Early Start D/HH services:
All districts within the Oxnard Elementary SD Early Start Program and the Ventura USD ES Program.
Contact person: Launice Walker, VUSD ECSE, (805) 672-2705 x2213

Rainbow Connection Referral Form



DATE _____

I would like to talk to another parent.

Me gustaría recibir una llamada de otro padre o madre.

Please email me information on trainings and activities for families.

Por favor envíe por correo electrónico información sobre entrenamientos y actividades para familias.

Email address/Correo electrónico

Other _____

Otro _____

I have been given information on Rainbow, I do not wish for a call at this time.

Yo tengo información de Rainbow. En este momento no deseo una llamada.

Child's Name: _____

Nombre del niño

Diagnosis: _____ **D.O.B:** _____ **Age:** _____ **Sex:** M F
(If known) Diagnóstico (si lo sabe): fecha de nacimiento edad Sexo:

Parent's Name: _____

Nombre del padre o madre:

Address: _____

Domicilio: _____
_____ **Zip** _____

Family Language is: _____

Idioma de la familia:

Daytime Phone: _____ **Evening Phone:** _____

Numero de teléfono de día: _____ **de Noche:** _____

Parent Signature: _____

Firma del padre:

Referred by : _____

Referido por:

(Mail to: Rainbow 2401 E. Gonzales Road #100 Oxnard, CA 93036 or fax 988-9521)

ASSESSMENT

ASSESSMENT

The assessment process must be multidisciplinary, and both agencies should collaborate together to assess potential dually served infants. The parents must give consent to assessment using the Parent Consent form (previous section). The assessment may be completed in conjunction with the Early Start Intake Interview Worksheet.

The school district ECSE may include as part of their multidisciplinary team a school nurse, psychologist, speech therapist, vision or hearing specialist. Additional assessments may be conducted by specialized staff as recommended by the ECSE. Proof that a multidisciplinary team was used is demonstrated by:

- Signatures on Summary of Assessment report
- A separate report submitted by a team member(s)
- Names listed on Family Approval page of the IFSP

Assessments must be completed within the 45 day timeline, and an IFSP meeting held.

The Assessment report will include:

- Family/Child Information
- Background Medical Information
- Assessment Purpose and Location
- Assessment Information – Indicate assessment tools used. Also include a statement regarding validity and cultural appropriateness of assessment tool(s) and if the infant/ toddler's response is a reliable predictor of his/ her development.
- Assessment results – must address these areas:
 - Gross Motor Skills
 - Perceptual/ Fine Motor Skills
 - Cognitive Development
 - Communication Development (Receptive and Expressive)
 - Adaptive/ Self-help Development
 - Social/ Emotional Development
- Summary
- Recommendations (including statement of eligibility)

When choosing an assessment tool consider the following:

- Use of a normed or standardized tool
- Assessment procedures that are not racially or culturally discriminatory
- Tool(s) that are considered to be valid for the suspected disability of the child

Use the attached form "Summary of Assessment/ Present Levels of Development" form or the attached Assessment Report Template.

Ventura County Early Start Program
Programa de Servicios de Intervención del Condado de Ventura
Individualized Family Service Plan (IFSP)
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR (IFSP)

SUMMARY OF ASSESSMENT/PRESENT LEVELS OF DEVELOPMENT

RESUMEN DE EVALUACION/NIVELES DE RENDIMIENTO ACTUALES

For Initial and Annual IFSPs, this form must be completed and attached to the IFSP.

If a separate report form is used, it must address all elements below.

CHILD'S NAME/NOMBRE: _____	DOB/FDN: _____
Address/Domicilio: _____	Categorical Age/Edad Categórica: _____
Phone/Teléfono: _____	Adjusted Age/Edad ajustada: _____
Date of Assessment(s)/Fecha de evaluación(es): _____	

Assessment Purpose & Location: _____

Assessments used/Evaluaciones utilizadas: _____

Assessor initials: _____

_____ Evaluation procedures were selected so as not to be racially or culturally discriminatory.

_____ The assessment tools used are considered to be valid for the suspected disability of this child.

_____ Assessment results appear to be reliable indicators of child's developmental abilities (or)

_____ Although test reliability may have been affected to an unknown degree due to _____, the results are as reliable as possible.

HEALTH/SALUD:

Health Status/Salud _____ Vision/Visión _____ Hearing/Audiencia _____

GROSS MOTOR/MOTORA (*large movement/movimiento amplio*):

PERCEPTUAL/FINE MOTOR/PERCEPTUAL/MOTRIZ FINA (*small movement/movimiento chico*):

COGNITIVE DEVELOPMENT/DESARROLLO COGNITIVO (*how child responds to environment, solves problems/como el niño responde al ambiente, resuelve problemas*):

COMMUNICATION DEVELOPMENT/DESARROLLO DE LA COMUNICACION (*language and speech/habla y lenguaje*)

Receptive/Receptivo (*understanding Comprension*):

Expressive/Expresiva (*making sounds/haciendo sonidos, talking/hablado*):

SOCIAL/EMOTIONAL DEVELOPMENT/DESARROLLO SOCIAL/EMOCIONAL (*how child relates to others/cómo el niño se relaciona con otros*):

ADAPTIVE/SELF-HELP DEVELOPMENT/ADAPTACION/DESARROLLO DE AUTO-AYUDA (*sleeping, eating, dressing, toileting/durmiendo, comiendo, vestirse, ir al baño*):

ADDITIONAL COMMENTS/COMENTARIOS ADICIONALES:

Assessor/Asesor: _____	Assessor/Asesor: _____
Title/Título: _____	Title/Título: _____
Agency/Agencia: _____	Agency/Agencia: _____

Ventura County Early Start Program
Programa de Servicios de Intervención del Condado de Ventura

ASSESSMENT REPORT TEMPLATE

Child's Name: Infant Baby

Birthdate: 9/19/09

Chronological Age: 1 month

Assessor: Early Childhood Special Educator

Date of Report:

Date of Assessment:

Parent Name: Mom & Dad Baby

UCI Number:

Background/ Medical Information

Infant Baby is a 1 month old male who was referred to Early Start due to ----- . He was born via -----
----. His current weight is ----- and length is ----- . He is under the care of Dr. ----- He is also
being seen by ----- . Vision or hearing concerns at this time. Medications ----- .Please refer to
Early Start Intake Interview Worksheet for complete family and medical information.

Assessment Purpose and Location

The purpose of this assessment is to determine if Infant Baby would benefit from early intervention services and to provide a picture of his overall developmental profile at this time. As areas of strength and possible needs are identified, it may be important to conduct further specialized assessments to assist in determining what interventions should be considered to support his development. The assessment was conducted in his home in the presence of his mother and Tri-Counties Regional Center Service Coordinator _____.

Assessment Information

In order to obtain an accurate assessment of Infant Baby's current levels of functioning observation, HELP Strands, and Developmental Profile III were used. **The Early Start Interview was also used which includes questions designed to reflect family beliefs and values as they relate to the assessment content, process, and child development. The assessment tools used are considered to be valid for the purpose used and to be culturally appropriate for the child and family. It is believed that Infant Baby's response to the assessment is a reliable predictor of his/ her development.**

Assessment Results

Gross Motor: *Refers to large body movements, balance, and coordination. Coordinated motor tasks build the foundation for exploration and learning, and are crucial to the ability to vocalize and speak.*

Perceptual/ Fine Motor: *Refers to small body movements, and ability to manipulate items in the environment.*

Cognitive Development: *Refers to the hierarchy of the child's typical level of play to include attention and exploration, functional understanding of objects, awareness of routines and sequences.*

Communication Development: *Refers to responses and understanding demonstrated by a child to directions and requests that involve actions such as pointing, facial expression, tone of voice and words.*

Adaptive/ Self Help: *Refers to the ability to initiate and perform age appropriate tasks moving to independence. This includes maintaining attention and the ability to determine what to attend to and what to screen out, eating patterns, sleeping patterns, self motivation and personal responsibility.*

Social / Emotional Development: *Refers to the ability to form attachment and interact with adults and peers, expression of feelings, affect self-concept, coping and awareness of social role.*

Summary

Based upon the information provided by the HELP Strands and Developmental Profile III, Infant Baby is demonstrating skills that range between birth and 1 month of age.

Recommendations

It is recommended that Infant Baby enroll in the Early Start program to address developmental delays, provide parent support, and parent education. Early Start will serve Infant Baby in the Solely Low Incidence (SLI) category of _____ through the _____ school district. A referral was made to CCS with the knowledge that ----- meets the eligibility criteria for CCS. A referral was also made to Rainbow Connection.

If I can be of further assistance, please do not hesitate to contact me.

Early Childhood Special Educator

School Psychologist

School District

Phone Number

Email Address

Teacher for the Vision Impaired

DHH Specialist

ELIGIBILITY

ELIGIBILITY

Eligibility for Solely Low Incidence (SLI):

1) Meets CCR Title 5 3030 disability for Hearing Impairment, Deaf/ Blind, Visual Impairment or Orthopedic Impairment

- Hearing Impairment- A pupil has a hearing impairment, whether permanent or fluctuating, which impairs the processing of linguistic information through hearing, even with amplification, and which adversely affects educational performance. Processing linguistic information includes speech and language reception and speech and language discrimination.
- Deaf/Blind- A pupil has concomitant hearing and visual impairments, the combination of which causes severe communication, developmental, and educational problems.
- Visual Impairment- A pupil has a visual impairment which, even with correction, adversely affects a pupil's educational performance.
- Orthopedic Impairment- A pupil has a severe orthopedic impairment which adversely affects the pupil's educational performance. Such orthopedic impairments include impairments caused by congenital anomaly, impairments caused by disease, and impairments from other causes.

– and –

2) Requires Intensive Special Education and related services by meeting **one** of the following:

Functioning at or below 50% of his/ her chronological age in any of the following:

- Cognitive development
- Motor (*gross/fine*)
- Language (*expressive/receptive*)
- Social/emotional
- Visual development

- or -

Functioning between 51% and 75% of his/ her chronological age level in any 2 of the above areas.

- or –

Has a disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.

Eligibility for dually served:

Children served by both schools and TCRC must meet eligibility criteria for both agencies.

Infants and toddlers are eligible for Early Start services through TCRC if they have:

1. Established risk conditions
2. Developmental delay. The eligibility criteria for deciding if an infant or toddler has a developmental delay are as follows:
 - 0-23 months, a 33% delay in one or more areas
 - 24-36 months, a 50% delay in one area or 33% in two or more areas

The areas of delay are:

- Cognitive development
- Physical and motor development
- Communication development
- Social or emotional development
- Adaptive development.

Eligibility for TCRC services will be determined by TCRC once the assessment report has been reviewed by their team.

Children who are eligible for Early Start services through TCRC may be dually served with the school district program if they also meet school district eligibility criteria:

1. Meet CCR Title 5 Section 3030 eligibility for any one of the following:

- Hearing Impairment
- Deaf
- Deaf/ Blind
- Orthopedic Impairment
- Visual Impairment
- Speech & Language Impairment
- Autism
- Mental Retardation
- Emotional Disturbance
- Other Health Impairment
- Multiple Handicaps
- Traumatic Brain Injury

– and –

2. Require intensive Special Ed. and related services by meeting one of the following:

- 50% delay in one of the areas above under SLI - or -
- 25% delays in 2 of the areas - or -
- A disabling medical condition, congenital syndrome which the IFSP team determined has a high predictability of requiring intensive special ed. services

See attached **Statement of Eligibility for Early Start** form and sample. See attached “pocket guide.”

Ventura County Early Start Program STATEMENT OF ELIGIBILITY FOR EARLY START

Name _____	DOB _____	UCI _____
------------	-----------	-----------

REGIONAL CENTER

ELIGIBLE under California Early Intervention Services Act

Reasons (*mark and describe*)

- Developmental delay:
- | | | |
|---|--|---|
| <input type="checkbox"/> Motor | <input type="checkbox"/> Communication | <input type="checkbox"/> Adaptive/Self Help |
| <input type="checkbox"/> Social/Emotional | <input type="checkbox"/> Cognitive | |

- Established risk: Dx _____
- ICD-9 Codes _____

_____	Date	_____	Date
Service Coordinator		Branch Manager or Designee	
_____	Date	_____	Date
Physician		Psychologist	

NOT ELIGIBLE

Reasons (*describe*): _____

_____	Date	_____	Date
Service Coordinator		Branch Manager or Designee	
_____	Date	_____	Date
Physician		Psychologist	

SCHOOLS

ELIGIBLE under California Code of Regulations, Title 5, Sections 3030 and/or 3031

Reasons (*describe*): _____

_____	Date	_____	Date
Service Coordinator		Administrator or Designee	

NOT ELIGIBLE

Reasons (*describe*): _____

_____	Date	_____	Date
Service Coordinator		Administrator or Designee	

SAMPLE - Only complete for SLI students.

**Ventura County Early Start Program
STATEMENT OF ELIGIBILITY FOR EARLY START**

Name <i>Infant Baby</i>	DOB <i>5/19/09</i>	UCI _____
-------------------------	--------------------	-----------

REGIONAL CENTER

ELIGIBLE under California Early Intervention Services Act
Reasons (mark and describe)

- Developmental delay:
- | | | |
|---|--|---|
| <input type="checkbox"/> Motor | <input type="checkbox"/> Communication | <input type="checkbox"/> Adaptive/Self Help |
| <input type="checkbox"/> Social/Emotional | <input type="checkbox"/> Cognitive | |

- Established risk: Dx _____
ICD-9 Codes _____

_____ Service Coordinator	_____ Date	_____ Branch Manager or Designee	_____ Date
_____ Physician	_____ Date	_____ Psychologist	_____ Date

NOT ELIGIBLE

Reasons (describe): _____

_____ Service Coordinator	_____ Date	_____ Branch Manager or Designee	_____ Date
_____ Physician	_____ Date	_____ Psychologist	_____ Date

SCHOOLS

ELIGIBLE under California Code of Regulations, Title 5, Sections 3030 and/or 3031

Reasons (describe): *Check Handy Pocket Guide, for example: Infant Baby is eligible as a child with an orthopedic impairment and at risk for developmental delay.*

_____ Service Coordinator	_____ Date	_____ Administrator or Designee	_____ Date
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NOT ELIGIBLE

Reasons (describe): _____

<i>Sign Here</i> _____ Service Coordinator	_____ Date	_____ Administrator or Designee	_____ Date
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Ventura County SELPA
EARLY START ELIGIBILITY
“Handy Pocket Guide”

Ventura County SELPA
EARLY START ELIGIBILITY
“Handy Pocket Guide”

Ventura County SELPA
EARLY START ELIGIBILITY
“Handy Pocket Guide”

Ventura County SELPA
EARLY START ELIGIBILITY
“Handy Pocket Guide”

- 3) Title 5 3030 disability:
HI, VI, SLI, SLP, Autism, MR, ED, D/B, OHI,
SOI

– and –

- 4) Requires Intensive Special Education and services by meeting **one** of the following:
- 50% delay in:
 - cognitive
 - motor (*gross/fine*)
 - language (*expressive/receptive*)
 - social/emotional
 - vision
 - 25% delays in 2 of the above areas
 - A disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.

- 1) Title 5 3030 disability:
HI, VI, SLI, SLP, Autism, MR, ED, D/B,
OHI, SOI

– and –

- 2) Requires Intensive Special Education and services by meeting **one** of the following:
- 50% delay in:
 - cognitive
 - motor (*gross/fine*)
 - language (*expressive/receptive*)
 - social/emotional
 - vision
 - 25% delays in 2 of the above areas
 - A disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.

- 1) Title 5 3030 disability:
HI, VI, SLI, SLP, Autism, MR, ED, D/B, OHI,
SOI

– and –

- 2) Requires Intensive Special Education and services by meeting **one** of the following:
- 50% delay in:
 - cognitive
 - motor (*gross/fine*)
 - language (*expressive/receptive*)
 - social/emotional
 - vision
 - 25% delays in 2 of the above areas
 - A disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.

- 1) Title 5 3030 disability:
HI, VI, SLI, SLP, Autism, MR, ED, D/B, OHI,
SOI

– and –

- 2) Requires Intensive Special Education and services by meeting **one** of the following:
- 50% delay in:
 - cognitive
 - motor (*gross/fine*)
 - language (*expressive/receptive*)
 - social/emotional
 - vision
 - 25% delays in 2 of the above areas
 - A disabling medical condition or congenital syndrome which the IFSP team determines has a high predictability of requiring intensive special education services.

INDIVIDUALIZED FAMILY SERVICE PLAN

INDIVIDUALIZED FAMILY SERVICE PLAN

The Individualized Family Service Plan (IFSP) is a legal document developed by the family, Service Coordinator, and service providers to initiate and facilitate requested services to the infant/ toddler and family. This paperwork will be reviewed every six months or at family request. Each review must include a new Summary of Services page.

The IFSP must include:

- Name of Service Coordinator. Person responsible for facilitating implementation and coordination of the IFSP.
- Early Intervention services. Statement of the frequency, amount, location, and method of delivering the services.
- Agency responsible for providing each service.
- Dates. Initiation of services, duration of services, anticipated review date. Use M/D/Y format.
- Justification if services will not be provided in the natural environment. The “natural environment” is defined as the environment the family and child would be accessing if the child did not have a disability, including the home and community locations which typically developing children may access. Examples of rationales for providing services in more specialized settings only accessed by children with disabilities and their families include “access to specialized professionals,” “access to specialized equipment not available in the home,” “parent does not want services in the home.”
- Family strengths, priorities, concerns and resources related to enhancing the development of their infant (only with family permission).
- Present levels of development including hearing, vision, health, gross or fine motor, cognitive, communication, social skills, and self-help skills. There must be evidence of input from all service providers, by participation or report.
- Outcomes. Major outcomes for the family and/or infant related to the special developmental needs of the infant. Outcomes must be measureable and stated in the parent’s terms. Consider the infant’s pre-literacy and language skills when writing outcomes. There must be an Outcomes and Services page for each service listed on Summary of Service page of the IFSP.
- Criteria, procedures, and timelines used to determine the degree of progress the child or family has made, and if changes are necessary.
- If the IFSP is a review, a statement of progress toward outcomes, in parent’s words.
- Transition. Steps to be taken towards transition to appropriate services when infant is three years old. Transition may begin as early as 2 years 6 months.

For solely low incidence children, the school district ECSE is responsible for the IFSP. For

dually served children, the school district ECSE completes a developmental assessment which includes present levels of development and participates in the development of the appropriate measurable outcomes. Ideally, the paperwork is completed when the Service Coordinator, parents, and school district ECSE are all together.

The school district ECSE will receive a copy of all paperwork generated by Regional Center, including Statement of Eligibility and Rainbow Referral. Parents receive a copy of "*Parent's Rights*" (in booklet or single page form) at the initial and annual IFSP. (Attached) ECSE will document that parent has received a legible copy of the IFSP and it has been fully explained. (See attached checklist for student file.)

The school district ECSE will forward a copy of each completed IFSP to the child's school district of residence. The ECSE will also forward information to the district CASEMIS clerk for each Solely Low Incidence and Dually served child. This information is collected by the California Department of Education for pupil count and funding purposes in December and June each year.

See IFSP forms attached:

- Summary of Early Intervention Services and sample
- Strengths, Priorities and Concerns and sample
- Outcomes & Services and sample
- Family Approval and sample
- IFSP Semi-Annual Review and sample

PARENTS' RIGHTS AND RESPONSIBILITIES IN THE EARLY START PROGRAM UNDER IDEA

EVALUATION AND ASSESSMENT

The determination of eligibility for Early Start in California includes a timely, comprehensive, multidisciplinary evaluation and assessment of every child under age three years who is suspected to be in need of early intervention services. If no parent or guardian is available or the child is a ward of the court, a knowledgeable surrogate parent who has no conflicting interest will be appointed by a regional center or LEA, under Title 17, Section 52175.

Procedural safeguards ensure that families are provided their rights under the law.

As a parent, you have the right to:

1. be fully informed of your rights under Early Start;
2. refer your child for evaluation and assessment, provide information throughout the process, make decisions, and give informed consent for your child's early intervention services;
3. understand and provide voluntary written permission or refusal before the initial evaluation and assessments are administered; Consent for evaluation and assessment is required only at the time of initial evaluation and assessment to receive services. (If consent is refused, the regional center or LEA may take steps to obtain an initial evaluation without parental consent.);
4. participate in the initial evaluation and assessment process including eligibility determination;
5. receive a completed initial evaluation and assessment within 45 days after the referral of your child to a regional center or an LEA;
6. participate in a meeting to share the results of evaluations and assessments; and
7. participate in all decisions regarding eligibility and services.

THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT (IDEA) REQUIRES THAT:

1. Evaluation and assessment materials are administered in the language of the parents' choice or other mode of communication, unless it is clearly not feasible to do so.
2. Evaluation and assessment procedures and materials are selected and administered so as not to be racially or culturally discriminatory.
3. Evaluation and assessment materials are appropriate to assess the specific areas of developmental need and are used for the specific purposes for which they were designed.
4. Evaluations and assessments are conducted by qualified personnel.
5. Evaluations and assessments administered to children with known vision, hearing, orthopedic, or communication impairments are selected to accurately reflect the child's developmental level.
6. Evaluations and assessments are administered in the five developmental areas, which include physical development (motor abilities, vision, hearing, and health status); communication development; cognitive development; adaptive development; and social or emotional development. Assessments and evaluations are ongoing while your child is in Early Start.
7. Evaluations and assessments shall be conducted in natural environments whenever possible.
8. Pertinent records relating to your child's health status and medical history are reviewed.
9. No single procedure is used as the sole criterion for determining your child's eligibility for early intervention services.

10. Interviews to identify family resources, priorities, and concerns regarding the development of your child and your family's needs are voluntary.

INDIVIDUALIZED FAMILY SERVICE PLAN (IESP)

An Individualized Family Service Plan (IFSP) is a written plan for providing early intervention services to an eligible child and the child's family. For an infant or toddler who has been evaluated for the first time, a meeting must take place within 45 days of the referral to the regional center or LEA to share the results of the evaluation, to determine eligibility, and, for children who are eligible, to develop the initial IFSP. Evaluation results and determination of eligibility may be shared with families prior to the first IFSP meeting.

A periodic review of your child's IFSP must take place at least every six months. A review may occur more frequently if there are any changes to the IFSP or if you request a periodic review with the regional center or LEA. The IFSP must also be reviewed annually to evaluate how your child is doing and to make any needed changes to the IFSP.

During the development and implementation of an IFSP, you have the right as the parent to:

1. attend the IFSP meetings and participate in developing the IFSP;
2. invite other family members to attend IFSP meetings;
3. invite an advocate or persons other than family members to attend and participate in the IFSP meetings;
4. have a copy of the complete IFSP;
5. have the contents of the IFSP fully explained in the language of your choice;
6. give consent to services listed on the IFSP. If you do not give consent to a service, it will not be provided. You may withdraw consent after initially accepting or receiving a service;
7. have services provided in the natural environment or an explanation of why that is not possible;
8. exchange information about your child among other agencies;
9. be notified in writing before any agency or service provider proposes or refuses to initiate or change your child's identification, evaluation, assessment, placement, or the provision of appropriate early intervention services to your child or your family. The notice must contain:
 - the action that is proposed or refused,
 - reasons for the action, and
 - all available procedural safeguards.

The notice must be presented in the language of your choice, unless it is clearly not feasible to do so, and may be translated so that you understand its contents; and

10. voluntarily use private insurance to pay for evaluation, assessment, and required early intervention services on the IFSP.

Mediation Conferences, Due Process Hearings, and State Complaints

In Early Start, parents have rights and protections to assure that early intervention services are provided to their children in a manner appropriate to their needs, in consideration of family concerns, and in compliance with applicable federal and State statutes and regulations. The following procedures are only for children under the age of three years.

As a parent, you have the right to:

1. request a due process hearing any time a regional center or LEA proposes or refuses to initiate or change the identification, evaluation, assessment, placement, and/or provision of appropriate early intervention service(s);

2. be informed of your right to file a complaint or a request for mediation and/or due process;
3. file a complaint if you believe there has been a violation of any federal or state statute or regulation governing early intervention services under Early Start including eligibility and services;
4. request a mediation conference immediately, prior to a complaint or due process hearing request, or at any time during the complaint/due process hearing processes to resolve a dispute related to any matter concerning federal or state statute or regulation governing early intervention services under Early Start; and
5. file a complaint if a due process decision fails to be implemented.

Mediation Conference

Mediation is a voluntary, non-binding, confidential process in which a neutral mediator facilitates settlement negotiations between you and another party. Voluntary mediation conferences are an informal way to resolve disagreements with early intervention service agencies or to address alleged violations of any state and federal statutes or regulations.

As a parent you have the right to:

1. file a request for mediation as the initial option for resolving a dispute or any time during the due process hearing or complaint process,
2. request a due process hearing or file a state complaint if the disagreement is not resolved,
3. refuse to participate in mediation ,
4. have an impartial person facilitate the mediation conference,
5. require that the mediation conference is carried out at a time and in a location that is reasonably convenient for you,
6. have all personally identifiable information maintained in a confidential manner, and
7. receive a written document outlining the agreements reached as a result of the mediation conference.

Requests for mediation are filed with the:
Office of Administrative Hearings
Attention: Early Start Intervention Section
2349 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
(916) 263-0654 Fax: (916) 376-6318

Due Process Hearings

All parents are encouraged to resolve differences at the lowest administrative level possible. When differences between you and a regional center or LEA cannot be resolved, due process hearings are available. You, as a parent, are encouraged to seek assistance from your child's service coordinator, the regional center, or the Special Education Local Plan Area (SELPA) office.

Circumstances leading to a due process hearing may be disagreements related to a proposal or refusal for identification, evaluation, assessment, placement, or services.

Your child will continue to receive the early intervention services identified on the IFSP that he/she is currently receiving unless you and the regional center or LEA otherwise agree to a change. If your disagreement involves a new service that has not started, your child will receive all services identified on the IFSP that are not in dispute. This does not include your regional center providing early intervention services after your child has reached 36 months of

age, as federal law and regulations do not allow states to pay for early intervention services under any circumstances once your child transitions from Early Start. The program or programs your child enrolls in subsequent to transition from Early Start is responsible for providing you and your child services for which he or she is eligible to receive.

Requests for a due process hearing are filed at the following address:*

Office of Administrative Hearings
Attention: Early Start Intervention Section
2349 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
(916) 263-0654 Fax: (916) 376-6318

**The due process hearing request form may be obtained from your service coordinator, the regional center, the LEA, and the Department of Developmental Services (DDS) website: www.dds.ca.gov/Forms/pdf/DS1802.pdf*

The due process hearing must be completed within 30 days of receipt of the request by the Office of Administrative Hearings. The timely issuance of the written decision may not be delayed by any concurrent voluntary local efforts to resolve the matter. The decision will be final unless appealed.

As a parent, you have the right to:

1. have the due process hearing conducted by an impartial person, not employed by an agency serving your child, who is knowledgeable in the laws relating to early intervention and the service needs of infants, toddlers, and families;
2. require that the proceeding is carried out at a time and in a location that is reasonably convenient for you;
3. have all personally identifiable information maintained in a confidential manner;
4. bring a civil action against the other party following completion of the proceeding if you disagree with the results;
5. receive services identified on the IFSP that are not in dispute; and
6. have mediation discussions kept confidential and not used as evidence in any subsequent due process or civil proceedings.

During a due process hearing, you also have the right to:

1. be accompanied and advised by counsel and/or by individuals with special knowledge with respect to early intervention services for children under age three years;
2. present evidence, confront, cross-examine, and compel the attendance of witnesses;
3. prohibit the introduction of any evidence at the proceeding that has not been disclosed to you at least five days before the proceeding begins;
4. obtain a written or electronic verbatim transcription of the proceeding; and
5. obtain written findings of facts and decisions within 30 days from the date the request is filed.

State Complaints

Any individual or organization may file a signed, written complaint against the DDS, the California Department of Education (CDE), or any regional center, LEA, or private service provider that receives Part C funds alleging violation of any state or federal early intervention statute or regulation. However, even though DDS is mandated to investigate any complaint it receives, state law does not allow disclosure of the Early Start recipient's personally identifiable information without written parental consent, other than authorized employees specified by the regional center or LEA.

Information or assistance in filing complaints is available from your child's service coordinator, the regional center office, or the SELPA. DDS and CDE are available for consultation regarding the filing of a complaint. Additional assistance is available from advocacy

organizations such as the State Council on Developmental Disabilities or Disabilities Rights California.

Complaints are filed directly with the:
Department of Developmental Services
Office of Human Rights and Advocacy Services
Attention: Early Start Complaint Unit
1600 9th Street, MS 2-15
Sacramento, CA 95814
(916) 654-1888 Fax: (916) 651-8210

Any individual or organization who files a complaint has the right to:

1. receive assistance in filing the complaint from a service coordinator, regional center, and/or LEA;
2. not be compelled to use any other procedures under the Education Code or the Lanterman Developmental Disabilities Services Act to resolve the complaint;
3. submit additional information to DDS that may be helpful to the investigation;
4. receive a final written decision within 60 days of the date DDS receives the complaint;
5. receive appropriate remedies that may include monetary reimbursement or other corrective action, and assurance that services will be provided appropriately in the future if the decision of DDS includes remedies for denial of appropriate services;
6. have any issue in a complaint that is not part of a due process hearing be resolved by DDS within 60 days of the receipt of the complaint;
7. be notified by DDS that the hearing decision is binding if an issue is being raised in a complaint that had previously been decided in a due process hearing involving the same parties; and
8. have any complaint resolved that alleges the failure of a public agency or private service provider to implement a due process decision.

The complaint must:

1. be in writing and contain a signed statement alleging that DDS, CDE, the regional center, LEA, or other service provider involved with Early Start has violated a federal or state law or regulation;
2. provide the name, address, and phone number of the complainant;
3. contain a statement of facts upon which the violation is based;
4. include the name of the party against whom the complaint is being filed;
5. have occurred not more than one year before the date the complaint is received by DDS unless a longer period is reasonable because the alleged violation continues for the child or other children, or
6. have occurred not more than three years before the date on which the complaint is received by DDS if the complainant is requesting reimbursement or corrective action as remediation of the complaint;
7. the complaint may also include, if applicable, a description of the voluntary steps pursued at the local level to resolve the complaint; and
8. be withdrawn if the Complainant elects to participate in mediation within the 60 day complaint investigation.

CHECKLIST FOR STUDENT FILE

Student Name:

45 Day Timeline End Date:

1. DART

____ Response within 48 hours to TCRC

Comments:

2. INTAKE

____ Schedule meeting with TCRC, Date: _____

____ Give Parent Rights

____ Give information on CCS and Hearing Conservation, if applicable

____ Give information to family about Rainbow Referral (or receive copy from TCRC)

Comments:

3. ASSESSMENT/REPORT

____ Report sent/faxed/mailed to TCRC, if applicable, Date: _____

Comments:

4. IFSP

____ IFSP scheduled, Date: _____

____ Take to IFSP:

- All About Me binder
- Enrollment Packet
- Report
- School calendar
- IFSP paperwork (if SLI)

Comments:

5. Office

____ Complete CASEMIS page

____ Send IFSP and report to District of Residence, if applicable

____ Copy of IFSP, report/assessment and school calendar mailed/mailed/faxed/given to parents

____ If any contracts needed, send paperwork to SELPA (Gina)

Comments:

SAMPLE-

Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura

INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

IDENTIFYING INFORMATION (INFORMACION)

Child's name / Nombre Infant Baby Male Female
First (primer) Middle (segundo) Last (apellido) (masculino) (femenino)

SS# _____ Birth date (fecha de nacimiento) 5/19/08

Home language (Idioma usado en casa) English Interpreter needed? (¿Necesita interprete?) yes (sí) no

Translated IFSP needed? (¿Necesita traducción del plan?) yes (sí) no Language (idioma) _____

Parent/Guardian (padre/tutor) Mom and Dad Baby

Street address (dirección) 1234 Main St. Camarillo, CA 93012

Mailing address (domicilio) Same as above

Home phone (teléfono) 805-555-1212 Work phone _____ Message phone _____
(de casa) (del trabajo) (para mensajes)

IFSP TYPE: (tipo de plan) Check appropriate box (Use MM/DD/YY)

Initial (inicial) Transition Planning (planeamiento de transición) This IFSP meeting (esta reunión) 5-19-10

Annual IFSP (plan anual) Periodic Review (revisión periódica) Projected review (revisión) 11-19-10

Semi-Annual Final [6 months or before] (6 meses o antes)

Projected annual review 5-19-11
(revisión annual proyectada)

Service Coordinator Your Name Agency Your school district Case Number _____
(cordinador/a de servicios) (agencia) (número de caso)

Summary of early intervention services (RS=required service; NRS=Non required service; O=Other services)

Resumen de los servicios de intervención temprana (RS=servicios requeridos, NRS=servicios no requeridos, O=otros servicios)

Service or Activity [Designate type of service] (servicio o actividad-designar un tipo)	Frequency & Amount Intensity (frecuencia y cantidad- Intensidad)	Individual or group (individuo o grupo)	Agency and/or Provider (agencia y/o proveedor)	Start/End Dates (fechas de comienzo/ fin) (M/D/YY)	Location * (localidad)	Funding source (origen de financiamiento)
<i>Service Coordination</i>	<i>Ongoing</i>	<i>?</i>	<i>Your school district</i>	<i>5-19-10 – 11-19-10</i>	<i>Phone/ Home/ Group</i>	<i>Your school district</i>
<i>Specialized instruction</i>	<i>30 min. 1x a week</i>	<i>?</i>	<i>Your school district</i>	<i>5-19-10 – 11-19-10</i>	<i>Home</i>	<i>Your school district</i>
<i>Family, Counseling, and home visits</i>	<i>30 min. 1x a week</i>	<i>?</i>	<i>Your school district</i>	<i>5-19-10 – 11-19-10</i>	<i>Home</i>	<i>Your school district</i>
<i>Infant/ Toddler playgroup</i>	<i>Your program time</i>	<i>?</i>	<i>Your school district</i>	<i>5-19-10 – 11-19-10</i>	<i>School Site</i>	<i>Your school district</i>
<i>Include any referrals made (CCS, Rainbow, Hearing Conservation)</i>	<i>One time only</i>	<i>?</i>	<i>Your school district</i>	<i>5-19-10 – 5-19-10</i>	<i>Home</i>	<i>Your school district</i>

*Justification if not in natural environment (Justifique el porqué de no en un ambiente natural) Access to specialized equipment not available in the home OR
parents do not want services in the home.

Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura

INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

Child's Name: (Nombre) _____

TO HELP IN ASSESSING YOUR CHILD'S NEEDS

(Para ayudar a evaluar las necesidades de su niño/a)

(voluntary on part of family)

(voluntario por parte de la familia)

What are your child's **strengths**? (*¿Cuales son las fortalezas de su niño/a?*) (What does he/she do best?) (*¿Que es lo que hace su niño/a mejor?*)

What are your **concerns** and **priorities** about your child's health and/or development?

(Cuales son sus preocupaciones y prioridades sobre la salud y/o el desarrollo de su niño/a?)

Please list family **resources** (example: community, insurance, friends & family help, transportation, church, child care) (*Por favor liste los recursos familiares (por ejemplo: comunidad, seguro, ayuda de amistades y familiares, transportación, iglesia, guardería)*)

What other things would you like to discuss? (*Otra cosa que quiera discutir*)

Ventura County Early Start Program
 Programa de Servicios de Intervención Temprana del Condado de Ventura
INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

OUTCOMES AND SERVICES
RESULTADOS Y SERVICIOS

Child's Name (<i>nombre</i>): _____	Date of Birth (<i>fecha de nacimiento</i>): _____
---------------------------------------	---

IFSP Type and date (*tipo de plan y fecha*):

- Initial (*inicial*) _____
 Semi-Annual (*semi-anual*) _____
 Annual (*anual*) _____
 Transition Planning (*plan de transición*) _____
 Other/Periodic (*otro/enmienda*) _____

Note: Use as many copies of this page as necessary to complete all outcomes.

MAJOR OUTCOMES (in parents' words) / Resultados Mayores (con las palabras de los padres)

ACTION PLAN / METHOD (Criteria, procedures, and time lines to determine progress) / Plan de acción/método (criterio, procedimiento y límite de tiempo para determinar el progreso)

<p>Date (<i>fecha</i>): _____</p> <p>(update in parents' words): (<i>revisela con las palabras de los padres</i>)</p>	<p>Date (<i>fecha</i>): _____</p> <p>(update in parents' words): (<i>revisela con las palabras de los padres</i>)</p>
---	---

 Parent signature or initial (*firma del padre ó inicial*)

 Parent signature or initial (*Firma del padre ó /inicial*)

SAMPLE-

Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura
INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

OUTCOMES AND SERVICES
RESULTADOS Y SERVICIOS

Child's Name (nombre): Infant Baby Date of Birth (fecha de nacimiento): 5/19/08

IFSP Type and date (tipo de plan y fecha): Check appropriate box and fill in meeting date (M/D/YY)

- Initial (inicial) _____
 Semi-Annual (semi-anual) _____
 Annual (anual) _____
 Transition Planning (plan de transición) _____
 Other/Periodic (otro/enmienda) _____

Note: Use as many copies of this page as necessary to complete all outcomes.

MAJOR OUTCOMES (in parents' words) / Resultados Mayores (con las palabras de los padres)

We want Infant to play like his friends.

ACTION PLAN / METHOD (Criteria, procedures, and time lines to determine progress) / Plan de acción/método (criterio, procedimiento y límite de tiempo para determinar el progreso)

Infant Baby and family will receive home visits, one time per week to address the following outcomes:

Infant Baby will:

- *Cooperatively play ball games with peers*
- *Engage in finger plays and nursery rhymes*
- *Propel self forward on tricycle or ride-on-toy*

Progress determined by parent/teacher/ therapist observation(s) by 11/19/10.

<p>Date (fecha): _____ (update in parents' words): (revisela con las palabras de los padres)</p> <p><i>When reporting progress at each semi and annual review, copy each previous 'Outcomes and Services' page and complete this section using the parent's words. Have parent sign or initial below. Attach copies to new IFSP.</i></p>	<p>Date (fecha): _____ (update in parents' words): (revisela con las palabras de los padres)</p>
---	---

Parent signature or initial (firma del padre ó inicial)

Parent signature or initial (Firma del padre ó /inicial)

Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura

INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

Child's Name (*Nombre*) _____ Birth date (*Fecha de nacimiento*) _____

MEDICAL SERVICES (*servicios médicos*):

Assistive technology has been considered for this child (*Ayuda tecnológica ha sido considerada para este niño/a*):

FAMILY SERVICES (*servicios familiares*):

OTHER IFSP PARTICIPANTS (*otros participantes del plan*):

The following individuals/agencies participated in the development of the IFSP either by attending the meeting or giving input and agree to carry out the plan as it applies to their role in the provision of entitled Early Intervention Services. (*Los siguientes individuos/agencias participaron en el desarrollo de este plan ya sea asistiendo a las juntas o proveendo información y acuerdan de llevar a cabo el plan como se aplica a sus cargos escrito en el suministro de servicios autorizados de intervención temprana*)

Name/ Title (<i>nombre/título</i>)	Agency/ Phone (<i>agencial/teléfono</i>)	Date (<i>fecha</i>)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Person providing input by telephone or writing: _____
(*persona dando información por teléfono ó por escrito*)

IFSP FAMILY APPROVAL (*aprobación de la familia*)

_____ I had the opportunity to help develop this Individualized Family Service Plan (IFSP) of _____ (total) pages.
(*Tuve la oportunidad de ayudar con el desarrollo de este plan de _____ páginas.*)

_____ I have received a copy of my rights under the Early Start program at this meeting.
(*He recibido una copia de mis derechos en esta junta.*)

_____ I understand my rights, the plan, and give permission of the service providers listed to carry out the plan with me, leading toward the agreed upon outcomes.
(*Entiendo mis derechos, el plan y doy permiso a los proveedores de servicios mencionados para desempeñar el plan conmigo, llegando a los resultados de común acuerdo.*)

_____ A copy of the program calendar has been provided which shows breaks in service for holidays or vacations.
(*He recibido una copia del calendario mostrando las fechas de descanso referente a los días festivos y vacaciones.*)

Parent/ Guardian Signature (*firma del padre/tutor*)

Date (*fecha*)

Parent/ Guardian Signature (*firma del padre/tutor*)

Date (*fecha*)

SAMPLE-

Ventura County Early Start Program
Programa de Servicios de Intervención Temprana del Condado de Ventura

INDIVIDUALIZED FAMILY SERVICE PLAN
PLAN INDIVIDUALIZADO DE SERVICIOS FAMILIAR

Child's Name (Nombre) Infant Baby Birth date (Fecha de nacimiento) 5-19-08

MEDICAL SERVICES (*servicios médicos*):

Child's doctor, insurance provider, etc.

Assistive technology has been considered for this child (*Ayuda tecnológica ha sido considerada para este niño/a*):

Write N/A -or- if applicable include.

FAMILY SERVICES (*servicios familiares*):

WIC, church, extended family, etc.

OTHER IFSP PARTICIPANTS (*otros participantes del plan*):

The following individuals/agencies participated in the development of the IFSP either by attending the meeting or giving input and agree to carry out the plan as it applies to their role in the provision of entitled Early Intervention Services. (*Los siguientes individuos/agencias participaron en el desarrollo de este plan ya sea asistiendo a las juntas o proveendo información y acuerdan de llevar a cabo el plan como se aplica a sus cargos escrito en el suministro de servicios autorizados de intervención temprana*)

Include names of each service provider.

Name/ Title (<i>nombrel/título</i>)	Agency/ Phone (<i>agencial/teléfono</i>)	Date (<i>fecha</i>)
<u>Parent(s)</u>		<u>5/19/10</u>
<u>Your Name/ SC/ ECSE</u>	<u>Your school district and phone</u>	<u>5/19/10</u>

Person providing input by telephone or writing: _____
(*persona dando información por teléfono ó por escrito*)

IFSP FAMILY APPROVAL (*aprobación de la familia*) **Have parent initial individual statements below.**

_____ I had the opportunity to help develop this Individualized Family Service Plan (IFSP) of _____ (total) pages.
(*Tuve la oportunidad de ayudar con el desarrollo de este plan de _____ páginas.*)

_____ I have received a copy of my rights under the Early Start program at this meeting.
(*He recibido una copia de mis derechos en esta junta.*)

_____ I understand my rights, the plan, and give permission of the service providers listed to carry out the plan with me, leading toward the agreed upon outcomes.
(*Entiendo mis derechos, el plan y doy permiso a los proveedores de servicios mencionados para desempeñar el plan conmigo, llegando a los resultados de común acuerdo.*)

_____ A copy of the program calendar has been provided which shows breaks in service for holidays or vacations.
(*He recibido una copia del calendario mostrando las fechas de descanso referente a los días festivos y vacaciones.*)

Parent/ Guardian Signature (*firma del padre/tutor*) Date (*fecha*)

Parent/ Guardian Signature (*firma del padre/tutor*) Date (*fecha*)

TRANSITION

TRANSITION

One of the major responsibilities of the Early Start Program is the transition from the Infant/Toddler Program to services at age three. In addition to assistance with referral to public school special education services, Early Start Service Coordinators may provide resources for community recreation, day care, and other programs. The following tools are utilized:

➤ **Transition Meeting**

When the child is between age 2 years 6 months and 2 years 9 months, the school district ECSE convenes a meeting which must include the child's parent or guardian and a representative from the child's district of residence if agreed upon by parent. Any direct service providers and agencies serving the family may be invited, based on the parents' preference. Please see the attached SELPA list of Part B Preschool contacts for district contacts in each district. If the child is dually served, the TCRC Service Coordinator is also included.

➤ **Transition Planning Form**

During this Transition Meeting (which may also serve as a semi-annual review), the transition planning form is completed (see sample enclosed). The participants agree to complete their tasks towards the child's successful transition from Early Start. The receiving school district will collaborate with the Early Start team to coordinate the timing of the referral, which must be made no later than 2 years 9 months. The Early Start Service Coordinator (or school district ECSE for dually served) will make the referral at the agreed upon time to include most recent IFSP and all assessment reports. (See attached Referral Cover sheet and checklist). S/he will also assist the family in the transition process, including completing and returning required paperwork and attendance at appointments. (See attached Transition timeline.)

➤ **"What's Next After Early Start?" booklet**

This booklet is available for all ECSEs to share information about transition with families. It is ideal to leave it in the home and then discuss it at periodic intervals. It is available in English and Spanish. Call the SELPA for free copies.

VENTURA COUNTY EARLY START PROGRAM
PROGRAMA DE SERVICIOS DE INTERVENCION TEMPRANA DEL CONDADO DE VENTURA

TRANSITION PLAN
PLAN DE TRANSICION

This form is used to facilitate discussion of each child's unique needs and to review options for services that may be necessary and appropriate when the child turns age three. *Esta forma es utilizada para facilitar información acerca de las necesidades individuales de cada niño y para discutir opciones de servicios que sean necesarias y apropiadas cuando el niño(a) cumpla tres años de edad.*

Date/Fecha: _____		DOB/FDN: _____		UCI #: _____		SSN#: _____			
Child's Name/Nombre del Niño: _____						<input type="checkbox"/> Male/Masculino		<input type="checkbox"/> Female/Femenino	
Address/Domicilio: _____									
Parent/Guardian/Surrogate/Padres/Guardian/Padre de Crianza: _____									
Home Phone/Telefono del hogar: _____				Work Phone/Telefono de trabajo: _____					
Home Language/Lenguaje de la familia: _____				School District/Distrito Escolar: _____					
Service Coordinator/Agency/Coordinadora de Servicios: _____						Phone/Telefono: _____			
Transition booklet provided/Folleto de transición proveído: <input type="checkbox"/> Yes/Si <input type="checkbox"/> No/No									
Date of Initial IFSP/Fecha de IFS Inicial: _____									
<input type="checkbox"/> Parent declined school district attendance/Padre rechazo la asistencia del distrito escolar									

1. Current Early Start services, including provider/Servicios de Comienzo Temprano actuales, incluyendo el proveedor: _____

2. Child's strengths/Fortalezas del niño: _____

3. Areas of concern related to transition and where skills are needed (home, community, daycare/preschool)/Áreas de preocupación relacionadas con la transición y habilidades necesarias (hogar, comunidad, guardería, preescola): _____

4. Family's plans for age three services/activities/Planes familiares para servicios/actividades de tres años. Address any anticipated gaps in service (summer vacation, family trips)/Identifique cualquier intervalo anticipado en servicios (vacaciones de verano, viajes familiares): _____

5. Special health care needs (medications, equipment, vision and hearing)/Necesidades medicas (medicamentos, equipo medico, vision y audición): _____

6. Program options discussed/Opciones de programas discutidas: _____

7. Eligibility for age three services:
Does the family want assessment for public school special education eligibility at age 3? Yes No

School District of Residence: _____

Referral to district made today Referral to be sent to district no later than: _____

Potential Areas of Assessment: _____

School District Contact Person: _____ Phone: _____ Email: _____

Individualized Education Program (IEP) team meeting to be held by: _____

Please invite my Early Start Service Coordinator to the IEP meeting.
Service Coordinator's Email: _____

Additional follow-up steps (if any. i.e. other data to be gathered, immunization records, medical records, appointments, etc.): _____

Does the family want assessment for Regional Center eligibility at age 3? Yes No

Areas of Assessment: _____

Who will contact parent: _____ Phone: _____ By When: _____

Individual Program Plan (IPP) meeting to be held by: _____

Additional follow-up steps (if any. i.e. other data to be gathered, immunization records, medical records, appointments, etc.): _____

8. Referral to Multidisciplinary, Multiagency Team Assessment (MMTA) Yes No

9. General notes: _____

10. Agreement to proceed:

- I have participated in developing this Transition Plan
- I agree with the steps outlined in this plan
- I give my permission for the individuals and agencies indicated to carry out the plan with me
- I give permission for the schools and Regional Center to share information and assessments that are needed to develop a program for my child at age 3:

11. Signed:

Parent/Guardian/Surrogate Parent(s) _____ Date _____

Regional Center Service Coordinator: _____

School District Representative: _____ Title/Agency: _____

Present Participated via telephone

Participant: _____ Title/Agency: _____

Family would like a referral to Rainbow Connection Family Resource Center Yes No

SAMPLE

Ventura County Early Start Program

Programa de Servicios de Intervención Temprana del Condado de Ventura

TRANSITION PLAN

PLAN DE TRANSICION

This form is used to facilitate discussion of each child's unique needs and to review options for services that may be necessary and appropriate when the child turns age three. *Esta forma es utilizada para facilitar información acerca de las necesidades individuales de cada niño y para discutir opciones de servicios que sean necesarias y apropiadas cuando el niño(a) cumpla tres años de edad.*

Date/Fecha: <u>11/24/10</u>	DOB/FDN: <u>5-19-08</u>	UCI #: _____	SSN#: _____
Child's Name/Nombre del Niño: <u>Infant Baby</u>		<input checked="" type="checkbox"/> Male/Masculino	<input type="checkbox"/> Female/Femenino
Address/Domicilio: <u>1234 Main St. Camarillo, CA 93012</u>			
Parent/Guardian/Surrogate/Padres/Guardian/Padre de Crianza: <u>Mom and Dad Baby</u>			
Home Phone/Telefono del hogar: <u>805-555-1212</u>		Work Phone/Telefono de trabajo: _____	
Home Language/Lenguaje de la familia: <u>English</u>		School District/Distrito Escolar: <u>Your school district</u>	
Service Coordinator/Agency/Coordinadora de Servicios: <u>Your name</u>		Phone/Telefono: <u>Your phone number</u>	
Transition booklet provided/Folleto de transición proveído: <input checked="" type="checkbox"/> Yes/Si <input type="checkbox"/> No/No Date of Initial IFSP/Fecha de IFS Inicial _____			
Give "What's Next After Early Start"			
<input type="checkbox"/> Parent declined school district attendance/Padre rechazo la asistencia del distrito escolar			

1. Current Early Start services, including provider/Servicios de Comienzo Temprano actuales, incluyendo el proveedor. List current services and providers.
2. Child's strengths/Fortalezas del niño: List the child's strengths using parent input.
3. Areas of concern related to transition and where skills are needed (home, community, daycare/preschool)/Areas de preocupación relacionadas con la transición y habilidades necesarias (hogar, comunidad, guardería, preescola):
List the concerns that the parent may have.
4. Family's plans for age three services/activities/Planes familiares para servicios/actividades de tres años. Address any anticipated gaps in service (summer vacation, family trips)/Identifique cualquier intervalo anticipado en servicios (vacaciones de verano, viajes familiares): List child's activities such as preschool plans, community plans (such as Park and Recreation, NFL, other activities). List any anticipated gaps if school is not in session when child is turning 3 or mention if family will be unavailable.
5. Special health care needs (medications, equipment, vision and hearing)/Necesidades medicas (medicamentos, equipo medico, vision y audición): Hearing/ vision results. List any medications Discuss general health Address any equipment that may be used.
6. Program options discussed/Opciones de programas discutidas: Any programs that are discussed at this meeting may be listed here.
7. Eligibility for age three services (Elegibilidad para servicios después de los tres años):
Does the family want assessment for public school special education eligibility at age 3? Yes No
(¿La familia quiere evaluación por medio de la escuela pública para elegibilidad de servicios especiales?) Si No
School District of Residence (Distrito escolar en su área residencial): District in which child resides.
Select one:
 Referral to district made today (Referencia al distrito hecha hoy)
 Referral to be sent to district no later than: Fill in if applicable (Referencia debe ser enviada al distrito antes de)

Potential Areas of Assessment (Áreas potenciales para evaluar): example: "Speech Language", "Cognitive", "Motor"

School District Contact Person (Contacto del distrito escolar): Name of Contact

Phone (Teléfono): Contact's phone number Email (Correo electrónico): Email of contact person

Individualized Education Program (IEP) team meeting to be held by: Child's third birthday.

(La reunión del Plan Individualizado de Educación (IEP) será)

If parent wants the service coordinator to attend, please complete.

Please invite my Early Start Service Coordinator to the IEP meeting. (Por favor de invitar a mi coordinadora de servicios a la junta del IEP)

Service Coordinator's Email (Correo electrónico de mi coordinadora): _____

Additional follow-up steps (if any. i.e. other data to be gathered, immunization records, medical records, appointments, etc.)
Adicionales medidas de seguimiento (si algo. e.j. otra información que tiene que ser documentada, registro de vacunas, expediente medico, citas, etc.): _____

i.e. Need 2 forms of proof of residence (such as utility bills), Copy of birth certificate, etc.

If applicable, please complete.

Does the family want assessment for Regional Center eligibility at age 3? Yes No
(¿La familia quiere evaluación para elegibilidad de servicios por el Centro Regional después de los 3 años? Si No)

Areas of Assessment (Áreas de evaluación): _____

Who will contact parent (Quién se pondrá en contacto con los padres): _____

Phone (Teléfono): _____ By When (Antes de): _____

Individual Program Plan (IPP) meeting to be held by (La reunión del Plan Individualizado del Programa (IPP) será): _____

Additional follow-up steps (if any. i.e. other data to be gathered, immunization records, medical records, appointments, etc.)
Adicionales medidas de seguimiento (si algo. e.j. otra información que tiene que ser documentada, registro de vacunas, expediente medico, citas, etc.): _____

8. Referral to Multidisciplinary, Multiagency Team Assessment (MMTA) Yes No **Discuss with SC,**
(Referencia al Equipo Multidisciplinario, Evaluación por Varias Agencias (MMTA) Si No **if appropriate.**

9. General notes (Notas generales): _____

10. Agreement to proceed (Acuerdo para proceder): **Parent to complete this section.**

- I have participated in developing this Transition Plan (He participado en el desarrollo de este Plan de Transición)
- I agree with the steps outlined in this plan (Estoy de acuerdo con los pasos descritos en este plan)
- I give my permission for the individuals and agencies indicated to carry out the plan with me (Doy mi permiso al personal y agencias indicadas para que sigan adelante con este plan conmigo.)
- I give permission for the schools and Regional Center to share information and assessments that are needed to determine eligibility of my child at age 3 (Doy permiso a las escuelas y al Centro Regional para que compartan información y evaluaciones que sean necesarias para determinar la elegibilidad de mi niño/a a la edad de 3 años.)

11. Signed (Firma):

Parent/Guardian/Surrogate Parent(s) _____ Date (Fecha) _____
(Padres/Guardián, Padres de Crianza)

Regional Center Service Coordinator (Coordinadora de Servicios del Centro Regional): _____

School District Representative (Representante del Distrito Escolar): _____

Title/Agency (Título/Agencia): _____

Present (Presente) Participated via telephone (Participo por teléfono)

Participant (Participante): _____ Title/Agency (Título/Agencia): _____

Family would like a referral to Rainbow Connection Family Resource Center (La familia gustaría una referencia al Centro de Conexión de Recursos Familiares)	<input type="checkbox"/> Yes (Si) <input type="checkbox"/> No Check appropriate box.
--	---

PRESCHOOL REFERRAL CONTACTS

<u>ATTENTION</u>	<u>DISTRICT</u>	<u>SITE</u>	<u>ADDRESS</u>	<u>CITY/ZIP</u>	<u>PHONE</u>	<u>FAX</u>	<u>E-MAIL</u>
SHAYNA TOLKMITT, SCHOOL PSYCHOLOGIST	BRIGGS SCHOOL DISTRICT	OLIVELANDS SCHOOL	12465 FOOTHILL RD.	SANTA PAULA CA 93060	933-2254	933-1111	sstern-tolkmitt@vcoe.org
KENDALL FORRESTER, LEAD COORDINATOR	CONEJO VALLEY UNIFIED SCHOOL DISTRICT	UNIVERSITY CENTER PRESCHOOL	2801 ALTAS AVE.	THOUSAND OAKS CA 91360	492-4051,		kforrester@conejo.k12.ca.us
MARY WILLIAMS, COORDINATOR	FILLMORE UNIFIED SCHOOL DISTRICT		P.O. BOX 697	FILLMORE CA 93016	524-6033	524-6081	mwilliams@fillmore.k12.ca.us
ESTELA MACIAS, PROGRAM SPECIALIST	HUENEME SCHOOL DISTRICT		205 NORTH VENTURA ROAD	PORT HUENEME CA 93041	488-3588	986-8129	emacias@huensd.k12.ca.us
RUTH SHAW, PROGRAM SPECIALIST	LAS VIRGENES UNIFIED SCHOOL DISTRICT	BUTTERCUP SCHOOL	6098 NORTH VENTURA ROAD	AGOURA CA 91301	818-597-2513	597-2156	rshaw@lvusd.org
ROBIN SAKAKINI, PSYCHOLOGIST	MESA UNION SCHOOL DISTRICT		3901 NORTH MESA SCHOOL ROAD	SOMIS CA 93066	485-1411	445-4387	rsakakini@vcoe.org
JAN VAN ATTA, PSYCHOLOGIST	MOORPARK UNIFIED SCHOOL DISTRICT	EARLY CHILDHOOD CTR	240 FLORY AVENUE	MOORPARK CA 93021	378-6384	530-3885	jvanatta@mrpk.org
SHAYNA TOLKMITT, PSYCHOLOGIST	MUPU SCHOOL DISTRICT	MUPU SCHOOL	4410 N. OJAI RD.	SANTA PAULA, CA 93060	525-6111		sstern-tolkmitt@vcoe.org
DEREK IHORI, PROGRAM SPECIALIST	OAK PARK UNIFIED SCHOOL DISTRICT	DISTRICT OFFICE	5801 EAST CONIFER STREET	OAK PARK CA 91377	818-735-3224	818-735-3243	dihori@oakparkusd.org
TAFFY NOLAN, PSYCHOLOGIST	OCEAN VIEW SCHOOL DISTRICT		4200 OLDS RD.	OXNARD CA 93033	986-6742	986-6797	tnolan@oceanviewsd.org
SHAYNA TOLKMITT, PROGRAM SPECIALIST	OJAI UNIFIED SCHOOL DISTRICT		P.O. BOX 878	OJAI CA 93024	640-4300, XT 1051	640-4321	sstern-tolkmitt@vcoe.org
ED THOMPSON, MANAGER, SPECIAL EDUCATION	OXNARD ELEMENTARY SCHOOL DISTRICT	EDUCATION SERVICE CTR	1051 SOUTH 'A' STREET	OXNARD CA 93030	487-3918 XT 513	487-9648	ethompson@oxnardsd.org
LORI BOWE, PSYCHOLOGIST	PLEASANT VALLEY SCHOOL DISTRICT		600 TEMPLE AVENUE	CAMARILLO CA 93010	445-8676	445-8808	lbowe@pvsd.k12.ca.us
CRISTINA IBARBIA, PSYCHOLOGIST	RIO SCHOOL DISTRICT		2500 VINEYARD AVENUE	OXNARD CA 93036	485-3111 983-0277	983-0221	cibarbia@rio.k12.ca.us
KARI SKIDMORE, PRINCIPAL	SANTA CLARA SD		20030 E. TELEGRAPH ROAD	SANTA PAULA, CA 93060	525-4573	525-4985	kskidmore@scesd.k12.ca.us
KRISTI GROOMS, STUDENT SUPPORT SERVICES SPECIALIST	SANTA PAULA ELEMENTARY SCHOOL DISTRICT		P.O. BOX 710	SANTA PAULA CA 93061	933-8840	933-3023	kgrooms@spesd.org
PAT MADDEN, PSYCHOLOGIST	SIMI VALLEY UNIFIED SCHOOL DISTRICT		875 EAST COCHRAN STREET	SIMI VALLEY CA 93065	520-6705, XT. #1	520-6670	pmadden@simi.k12.ca.us
PATTI PAPE, PRINCIPAL	SOMIS UNION SCHOOL DISTRICT		P.O. BOX 900	SOMIS CA 93066	386-5711, XT. 36	386-4596	ppape@somis.k12.ca.us
VANESSA PEREZ, PSYCHOLOGIST/ PROGRAM SPECIALIST	VENTURA UNIFIED SCHOOL DISTRICT	EARLY INTERVENTION CENTER	10731 DARLING ROAD	VENTURA CA 93004	672-2705, X. 2206	672-0427	vanessa.perez@venturausd.org

VENTURA COUNTY EARLY START PROGRAM
Referral from Early Start Program to School District
for Special Education Assessment

From: Regional Center Office TCRC Oxnard TCRC Simi Valley North LA County

Service Coordinator: _____ Phone/ Email: _____

To: _____ School District: _____

Name of Child: _____

Date of Birth: _____ Early Start Eligibility Category: _____

Date of First IFSP: _____

Name of Early Start Service Coordinator: _____

Service Coordinator's Phone and Email: _____

Child's Primary Language: _____ Family's Primary Language: _____

Interpreter Needed? _____

Parent Name(s): _____

Address: _____

City/Zip: _____

Parent phone(s): _____

School District of Residence: _____

Date of transition meeting with school: _____

School representative in attendance: _____

(For referrals sent after 33 months only):

Parent Approval: _____ Date: _____

Early Start records attached:

- Most recent IFSP
- Most recent Assessment Reports

Date Referral Given/ Sent to District:

For Regional Center Use only

Date Referral Received by District:

For District Use only

VENTURA COUNTY EARLY START PROGRAM
Referral from Early Start Program to School District
for Special Education Assessment

SAMPLE-

From: Regional Center Office TCRC Oxnard TCRC Simi Valley North LA County

Service Coordinator: Mickey Mouse Phone/ Email: heyyou@email.com

To: Program Specialist School District: Your School District

Name of Child: Infant Baby

Date of Birth: 5-19-08 Early Start Eligibility Category: Hearing Impaired

Date of First IFSP: 5-31-08

Name of Early Start Service Coordinator: Your Name

Service Coordinator's Phone and Email: Your phone and email

Child's Primary Language: English Family's Primary Language: English

Interpreter Needed? No

Parent Name(s): Mom and Dad Baby

Address: 1234 Main St.

City/Zip: Camarillo, CA 93012

Parent phone(s): 805-555-1212

School District of Residence: Your District

Date of transition meeting with school: 11-24-10

School representative in attendance: School Psychologist

(For referrals sent after 33 months only): * If applicable parent must sign

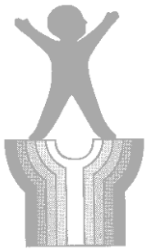
Parent Approval: _____ Date: _____

Early Start records attached: *Checklist for service coordinator*

- Most recent IFSP
- Most recent Assessment Reports

Date Referral Given/ Sent to District: _____ For Regional Center Use only

Date Referral Received by District: _____ For District Use only



Three Year Old Transition
Checklist for School District
“Part B”
Preschool Assessment Staff

Child’s Name: _____ DOB: _____

TCRC Service Coordinator: _____

Service Coordinator Phone: _____ Email: _____

School district staff should carefully document the following important dates and retain copies of the forms noted:

- Date contacted for a Transition IFSP meeting by Regional Center Service Coordinator
(Date must be agreed upon within 30 days of contact):

- Date of district attendance at Transition IFSP Meeting: _____
(School district may participate by teleconference if parent agrees)
(Copy of **Transition IFSP Form with School District Signature**)

- *Date referral received: _____
(Copy of **Referral Form** with date received stamped or initialed)

- Date Assessment Plan sent and received from parents:
Sent: _____ *Received: _____
(Copy of signed **Assessment Plan**)

Note reason timeline delayed (if any)

- Parent did not make child available for assessment
- School Holiday in excess of 5 days
- Other _____

- Date IEP Meeting scheduled: _____
(Copy of **signed IEP Meeting Notice received**)

- *Date IEP Meeting held: _____
(Copy of **Initial IEP**)

Name and Title of person completing this form: _____

* Required CASEMIS dates as of December 2008.

THREE YEAR OLD TRANSITION TIMELINE

Children transitioning from the Regional Center Early Start Program at 3 years old

Child turns 2.6

- 2.6 – Regional Center contacts schools and schedules transition IFSP meeting no later than 2.9, at a time which allows the IEP to be held no later than the child’s 3rd birthday. The meeting date must be agreed upon within 30 days of the contact. District staff should make every effort to schedule the meeting so that the referral can be made early enough to complete the assessment prior to the child’s 3rd birthday.
 - Between 2.6 – 2.9 Required transition IFSP meeting held at location convenient to family. Schools and regional center must be in attendance. (School district may participate by telephone if parent agrees).
 - Purpose = to meet family, discuss timing of referral, share program options, consider areas of assessment
 - Regional Center completes form. Copy to schools.
 - Referral packet given to schools (either at the transition IFSP or at agreed upon time)
(If schools do not attend Transition IFSP, referral packet to be sent no later than 2.9)
 - Within 15 days of receipt of referral packet by district:
 - Assessment Plan sent to family (or)
 - Prior Written Notice to Parent of Action sent to family
 - Assessment Plan signed by parent
 - IEP Held
(within 60 days of receipt of signed Assessment Plan)
- Allowable Interruptions:
 - School Holidays in excess of 5 days
 - Breaks between regular school sessions
 - The timeline will continue on the first day after the Holiday or break.
 - If the signed Assessment Plan is received by district within 30 days or less of end of the regular school year, the assessment must be completed and IEP held within 30 days of start of new school year.
 - Referrals received by school after 2.10 – IEP not required to be held by 3rd birthday.

3 years old

Child starts program as soon as school program starts after 3rd birthday

CONTRACTS

CONTRACTS

The school district ECSE can arrange for services such as respite, transportation, or nutrition for families of Solely Low Incidence children, if needed. See attached memos for guidelines for transportation and respite. The ECSE must submit the information in writing to the SELPA Secretary, so that a contract can be drawn up.

The information necessary for a respite, nutrition or transportation contract is:

1. Name and birth date of child.
2. Address and phone number of child/family.
3. Name of provider of service.
4. Address of provider.
5. For transportation: the anticipated number of miles per month, and the reimbursed cost per mile (based on SELPA rates).
6. For respite and nutrition: the approved number of hours per month, and the reimbursed cost per hour (based on SELPA rates).
7. A copy of the IFSP. The services must be listed on the Summary of Early Intervention Services page. The funding source will be the Ventura County SELPA.

In general, the standard of service for respite care is 4 to 8 hours per week, to be determined by the ECSE based on the child/family's need. Respite may only be provided to free up the family to attend an Early Intervention Service such as parent education activities. The family will select the respite care provider and receive funds to reimburse him/her. A child with significant medical needs may require a skilled respite provider. The number of hours per week may increase or decrease, as would the rate. If the family does not have a skilled respite care provider in mind, one can be obtained through a contract that SELPA maintains with a nursing association. Certified nursing assistants and skilled nurses are available (check hourly reimbursement rate with SELPA).

The standard of service for transportation varies according to the child's needs. Transportation reimbursement may only be applied toward costs related to the infant attending an Early Intervention service, which would include therapies provided by CCS or private agencies, play group, etc. The service must be listed on the Summary of Services page of the IFSP. Mileage reimbursement can be determined by estimating the number of miles the family travels each month to address the child's needs, and reimbursed at the rate currently allowed by the Ventura County Office of Education.

When the contract is written, copies will be sent to the ECSE, the family, and the service provider. The service provider must submit a signed invoice stating the dates and hours that the service was provided (See sample). This invoice can be submitted once a month, and no later than the end of the contract period or June 10, whichever comes first. The ECSE must sign the invoice and have the School District Coordinator or Director sign it. The ECSE must make a copy to keep in the child's file before sending the invoice to the SELPA Director for a signature.

Fingerprinting for service providers is mandatory, with the exception of parents who are being reimbursed for costs. Service providers who are already under contract to SELPA have complied with the fingerprinting requirements (nutrition, skilled nursing, respite). No contract funds will be paid until the fingerprinting process is completed and results are obtained.



VENTURA COUNTY SPECIAL EDUCATION LOCAL PLAN AREA

5100 Adolfo Road, Camarillo, CA 93012

(805) 437-1560 FAX (805) 437-1599

www.venturacountyselpa.com

Mary E. Samples, Assistant Superintendent

May 20, 2010

To: Early Start Families being served by Ventura County SELPA School Districts

From: Mary E Samples, Assistant Superintendent

Subject: Changes in availability of transportation services as of July 1, 2010

This is to inform you of changes to availability of reimbursement for transportation services for Early Start families served by SELPA School Districts. Due to budgetary concerns at both the state and federal level, school districts and regional centers are required to be more careful about services that are to be legally provided. Two sources of law:

"Transportation and Related Costs includes the cost of travel (e.g., mileage, or travel by taxi, common carrier or other means) and other costs (e.g., tolls and parking expenses) that are necessary to enable a child eligible under this parent and the child's family to receive early intervention services." (Emphasis added)

34 Code of Federal Regulations Part 303 Section 303.12 (d)(15)

"An early intervention service is defined as (a service that) is provided or purchased through the regional center, local educational agency, or other participating agency. The State Department of Health Services, State Department of Social Services, State Department of Mental Health, and State Department of Alcohol and Drug Programs shall provide services in accordance with state and federal law...."

Title 14, California Early Intervention Services Act, Section 95020 (e) (1)

Therefore, starting July 1, 2010, your School District Service Coordinator will only be allowed to authorize transportation costs related to your child attending an Early Intervention Service, which would include therapies provided by CCS or private agencies, play group, etc. We will no longer be able to reimburse you for costs related to traveling to medical appointments.

**AGREEMENT
INDEPENDENT CONTRACTOR SERVICES**

THIS AGREEMENT, made this July 1, 2010 between **Ventura County Superintendent of Schools**, hereinafter referred to as "*Superintendent*", and *Mom Baby*, hereinafter referred to as "*Contractor*".

The Superintendent desires to engage the Contractor to render certain technical and/or specialized services and Contractor is specifically qualified to perform said services, the parties do therefore agree as follows:

1. SCOPE OF SERVICES

The Contractor shall perform all the necessary services provided under this contract in connection with and respecting Superintendent and shall do, perform, and carry out, in a satisfactory and proper manner, as determined by the Superintendent, the following:

To provide Transportation for Infant Baby, up to 100 miles per month for Early Intervention Services as specified on I7SP.

2. TIME OF PERFORMANCE

The services of the Contractor are to commence on *July 1, 2010*, and shall be undertaken and completed in such sequence as to assure their full completion in accordance with the purposes of this agreement, but in any event, all the services required hereunder shall be completed by *June 30, 2011*.

3. COMPENSATION

UPON PROPER INVOICING, Superintendent agrees to pay the Contractor at the rate of \$ N/A (hour), not to exceed the total amount of _____ or the lump sum of \$N/A, payable within 20 days of approval by the Program Manager designated below as Superintendent's contact. Said payment(s) to be made as follows:

Upon receipt of invoice from contractor and approval of Infant Specialist.

4. EXPENSES - (Program Manager initials the applicable option.)

____ A. The Contractor will not be reimbursed for travel or other expenses.

____ B. Travel and/or expenses will be reimbursed as follows:

Travel: Mileage at the current US rate of \$.50 per mile (*maximum .505*) up to the total of \$600 .

Other: (*Receipts required - cancelled checks are not accepted as a receipt*) List authorized expenses, limits and maximum amounts.

5. TERMINATION

This agreement may be terminated at any time by either party. In the event of cancellation prior to completion of the specified services, all finished or unfinished documents, data, studies, and reports prepared by the Contractor under this agreement shall, at the option of the Superintendent, become Superintendent's property and the Contractor shall be entitled to receive just and equitable compensation for any satisfactory work completed on such items.

Notwithstanding the above, the Contractor shall not be relieved of liability to the Superintendent for damages sustained by the Superintendent by virtue of any breach of the contract by the Contractor, and the Superintendent may withhold any payments to the Contractor for the purpose of setoff until such time as the exact amount of damages due the Superintendent from the Contractor is determined.

6. INDEPENDENT CONTRACTOR

It is expressly understood and agreed that the Contractor, while engaged in carrying out and complying with any of the terms and conditions of this contract, is an independent contractor and is not an officer, agent or employee of Superintendent. Contractor further understands and agrees that he or she is an independent contractor and that the filing and acceptance of this declaration creates a rebuttable presumption of his or her status as an independent contractor and that, as such, Contractor is not entitled to coverage under the California Workers' Compensation Insurance laws, Unemployment Insurance or any other benefit normally conveyed to Superintendent's employees. Contractor will be personally responsible for payment of all amounts due for Federal and State income taxes and Social Security taxes since these taxes will not be withheld from payments under this agreement.

Both Contractor and the Superintendent's Manager shall initial the attached "*IRS 20 Factor Check list*" indicating they have reviewed the "*Checklist*" and, by signing this contract, certify that the duties, terms and conditions of this agreement meet the definition of an Independent Contractor per IRS Guidelines.

7. SUBCONTRACTING

None of the services covered by this contract shall be subcontracted without the prior written consent of the Superintendent. The Contractor shall be as fully responsible to the Superintendent for the acts and omissions of his/her subcontractors, and of persons either directly or indirectly employed by him/her, as if the acts and omissions were performed by him/her directly.

8. INSURANCE

Contractor shall, at Contractor's sole cost and expense, provide for and maintain in force and effect, from the commencement of services until expiration of this agreement, a policy or policies of insurance covering Contractor's services. All insurance shall be with an insurance company with a rating of A or better, as rates by the current edition of Best's Key Rating Guide, published by A.M. Best Company, Oldwick, New Jersey 08858 and authorized to conduct business in the State of California.

Required Insurance coverage shall include: Comprehensive general liability and property damage insurance and comprehensive automobile liability insurance covering activities and operations of the Contractor. Such liability insurance shall provide a minimum coverage of \$1,000,000.

Contractor shall furnish to Superintendent, prior to commencement of services under this agreement, Certificates of Insurance as evidence of the coverage and limits stated above. Certificates of Insurance shall:

- A. Name the superintendent as additional Insured.
- B. Provide a minimum for 30 days advance written notice of cancellation or material changes.
- C. State that coverage afforded the superintendent as additional insured shall apply as primary and not excess to any insurance issued the Superintendent.

9. COPYRIGHT

Contractor hereby agrees that Superintendent shall be the sole owner of the copyright for any publications, writings, materials or product developed by or as a result of this agreement. Contractor shall maintain the confidentiality of any such materials produced.

10. ARBITRATION

Any dispute arising out of the performance of this agreement shall be resolved by binding arbitration in accordance with rules and procedures of the American Arbitration Association.

11. OBEY ALL LAWS

Contractor hereby agrees he/she will obey all local, state and federal laws in the performance of this contract, including prohibitions against discrimination.

12. INDEMNIFICATION

Contractor shall indemnify and hold harmless the Superintendent, its officers, agents and employees from every claim or demand made, and every liability, loss, damages, or expense of any nature whatsoever, which may be Incurred as a result of Contractor's performance under this agreement, except for liability resulting from the sole negligence or willful misconduct of the Superintendent, its officers, employees, or agents who are directly employed by the Superintendent, and except for liability resulting from the active negligence of the Superintendent.

IN WITNESS WHEREOF, the Superintendent and Contractor have executed this agreement as of the date first written above.

VENTURA COUNTY OFFICE OF EDUCATION
Ventura County SELPA

CONTRACTOR

Requested by: _____
Program Manager

Signature

Date: _____

Date: _____

Maximum Contract and Expense Amount:

Tax I.D. #: _____
(W-9 form must be on file)

Charge to Account: 013-5809-3385-0-5710-2200-000-400-0203-0

Contractor's Mailing Address:

Approved by: _____

Title: _____

Date: _____

IRS 20 FACTOR CHECKLIST

Below are the 20 factors used by the IRS to determine whether the control over a worker is sufficient to constitute an employer-employee relationship. If the relationship is an Independent Contractor, you should only be concerned with the results of the work, not the way in which it is performed. Though these rules are intended only as a guide (*the IRS says the importance of each factor depends on the individual circumstances*) they should be helpful in determining whether enough control is exercised to show an employer-employee relationship.

If you answer “Yes” to all of the first four questions, you're probably dealing with an independent contractor: “Yes” to any of the questions 5 through 20 means your worker is probably an employee.

1. Profit or Loss Can the worker make a profit or suffer a loss as a result of the work aside from the money earned from the project? *This should involve real economic risk - not just the risk of not getting paid.)*
2. Investment Does the worker have an investment in the equipment and facilities used to do the work? *The greater the investment, the more likely independent contractor status.)*
3. Works for More than One Firm Does the person work for more than one company at a time? *(This tends to indicate independent contractor status, but employees can also work for more than one business.)*
4. Services Offered to the General Public Does the worker offer services to the general public?
5. Instructions Do you have the right to give the worker instructions about when, where, and how to work? *This shows control over the worker.)*
6. Training Do you train the worker to do the job in a particular way? *(Independent contractors are already trained.)*
7. Integration Are the worker's services so important to your business that they have become a necessary part of the business? *This may show that the worker is subject to your control.)*
8. Services Rendered Personally Must the worker provide the services personally, as opposed to delegating tasks to someone else? *This indicates that you are interested in the methods employed, and not just the results.)*
9. Hiring Assistants Do you hire, supervise, and pay the worker's assistants? *Independent contractors hire and pay their own staffs.)*
10. Continuing Relationship Is there an ongoing relationship between the worker and yourself? *(A relationship can be considered ongoing if services are performed frequently, but irregularly.)*
11. Work Hours Do you set the worker's hours? *(Independent contractors are masters of their own time.)*
12. Full-Time Work Must the worker spend all of his or her time on your job? *(Independent contractors choose when and where they will work.)*
13. Work Done on Premises Must the individual work on your premises. or do you control the route or location where the work must be performed? *(Answering "no" doesn't by itself mean independent contractor status.)*
14. Sequence Do you have the right to determine the order in which services are performed? *(This shows control over the worker.)*
15. Reports Must the worker give you reports accounting for his or her actions? *This may tend to show Lack of independence.)*
16. Pay Schedules Do you pay the worker by the hour, week, or month? *Independent contractors are generally paid by the job or on commission, although by industry practice, some are paid by the hour.)*
17. Expenses Do you pay the worker's business or travel costs? *This tends to show control.)*
18. Tools and Materials Do you provide the worker with equipment, tools or materials? *Independent contractors generally supply the materials for the job and use their own tools and equipment.)*
19. Right to Fire Can you fire the worker? *(An independent contractor can't be fired without subjecting you to the risk of a breach of contract lawsuit, so long as the results meet specifications.)*
20. Workers Right to Quit Can the worker quit at any time, without incurring liability? *(An independent contractor has a legal obligation to complete the contract.)*

By affixing my initials below, I certify I have reviewed the above "Checklist".

Program Manager

Contractor

VENTURA COUNTY SELPA
INVOICE FOR
TRANSPORTATION EXPENSES

TO:

Ventura County SELPA
Attn: Fran Arner-Costello, Director
5100 Adolfo Road
Camarillo, CA 93012
(805) 437-1560

Date: _____

Name of Child: _____

Name of Transportation Provider: _____

Address: _____

*I submit the following expenses for **TRANSPORTATION**:*

DATE	LOCATION		ROUNDRIP MILEAGE	CHARGES (.485 ¢ P/MILE)	TOTAL
	TO	FROM			

Provider signature: _____ Date: _____

Infant Specialist signature: _____ Date: _____

Coordinator/Director signature: _____ Date: _____

SELPA signature: _____ Date: _____



Mary E. Samples, Assistant Superintendent

September 1, 2010

To: Early Start Families being served by Ventura County SELPA School Districts

From: Mary E Samples, Assistant Superintendent

Subject: Changes in availability of respite services as of September 1, 2010

This is to inform you of changes to availability of reimbursement for respite services for Early Start families served by SELPA School Districts. The following is excerpted from a March 2003 letter from Stephanie Lee, Director of the Office of Special Education Programs:

“The Code of Federal Regulations (CFR) §303.12(a) Part C regulations list 16 “types” of services included under “early intervention services”. The note following §303.12 indicates that the lists of services are not exhaustive. The note states “early intervention services may include such services as the provision of respite and other family support services.” The term “respite” as used in that note is not intended to mean “reprieve” or “rest” but rather a child care-type service provided to enable parent(s) to participate or receive other early intervention services in order to meet the outcomes on a child’s IFSP.

In order for a parent to develop the capacity to assist his/her child in meeting his/her developmental needs, the parent may need respite or other type of care for the child while the parent participates in appropriate early intervention activities. Families may need in-home or other care arrangements for their child in order for the family to participate in early intervention services that include a defined family component, i.e., family training or counseling services, psychological services, or social work. A family may need to participate in sign language classes in order to assist the child in developing communication skills or meet with a psychologist to design appropriate behavioral management strategies to use when the child engages in inappropriate behaviors. Although the provision of respite or other care arrangements may be necessary for some families to participate in appropriate early intervention activities, respite is not intended to serve as child-care or “baby-sitting” assistance in ordinary circumstances.”

Therefore, starting September 1, 2010, your School District Service Coordinator will only be allowed to authorize respite costs related to your child attending an Early Intervention Service, which would include participation in parent education activities or other parent support events.

VENTURA COUNTY SELPA
INVOICE FOR REIMBURSEMENT TO PARENTS FOR

RESPITE CARE EXPENSES

TO:

Ventura County SELPA
Attn: Fran Arner-Costello, Director
5100 Adolfo Road
Camarillo, CA 93012
(805) 437-1560

DATE: _____

Name of Child: _____

Name of Parent: _____

Name of Care Provider: _____

Address of Care Provider: _____

Name of other Care Provider: _____

Other Care Provider Address: _____

*I submit the following expenses for **RESPITE CARE**:*

DATE	RECEIPT NUMBER	HOURS	CHARGES <i>(For each time, attach signed receipt)</i>	TOTAL

Parent signature: _____ Date: _____

Infant Specialist signature: _____ Date: _____

Coordinator/Director signature: _____ Date: _____

SELPA signature: _____ Date: _____

CONTRACT #

ACCOUNT #013-5809-3385-2-5710-2200-000-410-

SERVICE GUIDELINES

SERVICES WHICH MAY BE PROVIDED BY SCHOOL DISTRICT TO CHILDREN WITH SPEECH AND LANGUAGE DELAYS

A. DEFINITIONS

1. Communication:

Information which is transmitted or conveyed from one person to another, and the method used to convey it. Can be accomplished in many ways: visual (signing, gesture), body position, auditory, tactile, and olfactory.

2. Language:

The organized set of symbols we use to communicate meaning about objects and relationships in our world. These symbols are combined according to rules that govern language. Symbols can be spoken, gestures, or written.

a. Receptive language refers to the skills involved in understanding language, including:

- The ability to hear differences in sounds and assign different meanings
- Being able to remember what is heard (e.g. following a 3-step direction)
- Understanding vocabulary and concepts
- Understanding grammatical forms, such as plurals, negatives, etc.

b. Expressive language refers to the skills involved in communicating one's thoughts and feelings to others, answering questions, relating events, and carrying on a conversation. These include:

- Combining sounds within a language to convey meaning
- Choosing word forms and word order appropriately
- Choosing the best words to express a thought

3. Speech:

The physical ability to make sounds and to pattern these sounds into words to communicate a message. There are three major aspects of speech:

- a. Voice: vibration of the vocal cords caused by the air stream passing through the larynx (voice box). The components of voice include quality (hoarse, weak, breathy), loudness, pitch, and resonance (vibration of air in the oral or nasal cavities).
- b. Articulation: the physical production of sounds in speech. The voice generated by the vocal cords is shaped into sounds by the palate, tongue, lips and teeth.
- c. Fluency (rhythm): sounds, words, and phrases flowing together smoothly during speaking, with pauses and stress to express meaning.

4. Pragmatics:
Social and behavioral awareness of non-verbal communication skills, including visual contact, turn taking and body language.
5. Oral-Motor Skills:
The complex muscle task which requires coordination between the cognitive and the central nervous system to produce speech and feeding skills.

B. METHODS OF DELIVERY:

These services may be provided individually or in small groups by an Infant Specialist in consultation with a Speech/ Language Specialist, **or** directly by a Speech/ Language Specialist. Methods of delivery to be determined by the IFSP team based on assessment results and recommendations.

C. INTERVENTION AVAILABLE:

1. Assessment:
 - a. Receptive/ Expressive
 - b. Pragmatic skills
 - c. Oral-Motor skills
2. Consultation Services:
Speech/ Language specialist to assist Infant Specialist in determining appropriate goals and activities. Can be an occasional or an on-going service.
3. Early Communication Skills:
Language-based and cognitive-based skills for pre-verbal children. Play skills, social intervention, early pragmatic and behavioral skills.
4. Articulation Therapy:
To include breath support, positioning of body, use of articulators for sound production. Children with structural anomalies, hearing loss, neuro-muscular involvement may be candidates for this intervention.
5. Augmentative Communication Systems:
Giving the child a means to interact with his environment to enhance learning and functional communication. Includes adaptive switch plates, communication boards (pictures, eye gaze, photos), gestural and sign language. Signing may be appropriate for children with a hearing loss, and for other children with expressive delays. Parent involvement is very important in this area.
6. Parent Education and Modeling:
Providing activities of developmentally appropriate speech and language skills, and play skills. Modeling interactions specific to the child's needs.

Guidelines for Direct Speech Therapy

Readiness Skills:

- Intent to communicate
- Ability to imitate
- Ability to attend to age appropriate tasks
- Understands cause and effect

Likelihood of Needing Speech Therapy:

- Discrepancy between expressive and receptive language skills
- Discrepancy between communication skills and other developmental areas
- Children with hearing loss
- Children with Down, Klinefelter, Cleft Palate, Cerebral Palsy, Prader-Willi, Williams, Turner, Fragile X, Angelmann, may need consultation or direct therapy depending on underlying physiological conditions, such as low or high tone, absence of structure, cranial/facial anomalies, neurological issues, poor motor planning, etc.
- Children with autism

Other Points:

- Children with DHH may or may not need direct speech therapy depending on other professionals and what they are doing in terms of language development

Areas that an SLP should work on:

- Speech and language assessment (receptive, expressive, pragmatic and oral motor skills)
- Voice
- Articulation therapy
- Fluency
- Oral motor language
- Augmentative communication systems
- Parent education and modeling

Areas that the Early Childhood Special Educator should work on:

- Pragmatics
- Early communication skills (pointing, gesturing, imitating)
- Functional communication
- Listening and following directions
- Parent education and modeling

Occupational Therapist:

- Oral motor feeding
- Assistive technology

GUIDELINES FOR SCHOOL DISTRICT CONSIDERATION OF VISION SERVICES FOR CHILDREN SERVED SOLELY BY REGIONAL CENTER

IF THERE APPEARS TO BE A NEED FOR VISION SERVICES:

- Awareness of need for vision services (in addition to another ES eligibility)
- IFSP amendment – medical vision assessment, arranged by Regional Center
- Vision assessment yields a vision diagnosis:
 - Child Re-DARTed to schools
 - Schools review case
 - If there is space available, the receiving district will consider the child as a priority for dual service delivery
 - IFSP held to revise service plan
 - If they choose to serve, districts would require that all special education services be transferred to the school district.

PURCHASES

SELPA Funding for Purchase of Equipment, Supplies and Personnel Development

The serving school districts pay for all costs for staff salaries, benefits, office supplies, etc. in providing special ed services to eligible infants and toddlers up to their funded capacity.

The SELPA receives funding from a federal Early Start grant to pay for Early Intervention services to children with Solely Low Incidence disabilities which are beyond the typical mandate of Special Education and related services, including respite care and nutrition.

In addition, the SELPA allocates funds to each of the four regional Infant/Toddler programs for the following expenditures:

- Equipment
- Supplies
- Personnel Development
- Reimbursement for responding to DARTs and participating in intakes of Solely Low Incidence children beyond 200 days per year (known as “the dark month” in our SELPA)

Each district will receive an allocation of funds in the above categories according to their relative size, except for “Dark Month” reimbursement, which is standard.

The ECSE will work with the SELPA Early Start Secretary to procure supplies and reimbursements according to Ventura County Office of Education guidelines. All expenditures must be made by the fiscal close out each year. Any unexpended funds will be lost if not spent by close out.

MOU

See Early Start MOU